

may be utilized by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

11653

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Wilson</b> Middle <b>Althaus</b> Last <b>Althaus</b>		4. DATE OF DEATH Month <b>October</b> Day <b>26</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 Mar 1989</b>
9. AGE (In years lost birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Erco Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Althaus</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214 09 7505</b>	
17. INFORMANT <b>Ruby Althaus</b>		Address <b>Hyattsville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary artery occlusion</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease with</b> DUE TO <b>old myocardial infarct</b> (c) <b>old myocardial infarct</b>			INTERVAL BETWEEN ONSET AND DEATH <b>14</b> <b>144</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1984</b> to <b>Oct 26</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Oct 26</b> , 19 <b>60</b> , and that death occurred on <b>Oct 26</b> , 19 <b>60</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Tom Bergemann</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Teil Bergemann, M.D.</b>		22d. ADDRESS <b>4314 Gallatin Rd Hyattsville M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct 28, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>F</b>		25a. REC'D BY REGISTRAR <b>Hyattsville Md.</b> DATE <b>OCT 27 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

1175

CERTIFICATE OF DEATH

1175

1



1



11690

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE --- b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 Weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		d. STREET ADDRESS 2505 M Street, S.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ad-Sacorda Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVA Middle ALVEY Last		4. DATE OF DEATH Month Oct Day 20 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 15, 1886?
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Gov't. Clerk		10b. KIND OF BUSINESS OR INDUSTRY Gov't. Printing Off.	
11. BIRTHPLACE (State or foreign country) Wash., DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Beach		14. MOTHER'S MAIDEN NAME Florence Hamilton (Hammell)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Violet A. Quinn		Address 2302 Sheridan Street Hyattsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 yr + 10 yr +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1957, to Oct 1960, that I last saw the deceased alive on 10/19 1960, and that death occurred at 3:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M. Trozzo Jr.		ADDRESS (Street, city or town, state) 3501 Hamilton St. Hyattsville, Md	
DATE SIGNED 10/20/60			
PHYSICIAN'S NAME (Type) Frank M. Trozzo, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/22/60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.		ADDRESS 317 Pa. Ave., SE	
24a. REC'D BY REGISTRAR DATE OCT 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kears	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11691

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11655

Item 9 Film 0273 10-19-60 et

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>Hyattsville</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> c. STREET ADDRESS <b>16302 Tacumsett Place</b>	
3. NAME OF DECEASED (Type or print) First <b>Jesse</b> Middle <b>H</b> Last <b>Bailey</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 2, 1899</b>
9. AGE (In years last day) <b>61</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>20</b>	11. IF UNDER 24 HRS. Hours <b>10</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Jewelry repairs</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Arthur Bailey</b>		14. MOTHER'S MAIDEN NAME <b>Sue Vandyke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mada G Bailey Berwyn Heights Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Advanced Arteriosclerosis</b> DUE TO (c) <b>Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b> <b>year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 a. later in life</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1st</b> 19 <b>56</b> to <b>Oct 7th</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Oct 7th</b> 19 <b>60</b> , and that death occurred at <b>4 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Til Bergman</b>		22b. DATE SIGNED <b>OCT 7-1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>TIL BERGMAN</b>		22d. ADDRESS <b>4314 Falls Church Rd. Hyattsville Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct 9, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>	23d. LOCATION (City, town, or county) (State) <b>Hyattsville, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 13 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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CRIME CASE OF DEATH

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DECEASED

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DECEASED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

11692  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11656

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>M</b> Last <b>Baird</b>		4. DATE OF DEATH Month <b>October</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-27-1874</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>	
13. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		14. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
15. FATHER'S NAME <b>Charles A Miller</b>		16. MOTHER'S MAIDEN NAME <b>Clara F Seibring</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		18. SOCIAL SECURITY NO. <b>none</b>	
19. INFORMANT <b>Francelia M Baird</b>		Address <b>Hyattsville, Md.</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 h</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Febr. 1950</b> to <b>10-2 1960</b> , that (I) (we) last saw the deceased alive on <b>10-2 1960</b> , and that death occurred at <b>7:45</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Ronald S. Fleischer</b>		22b. DATE SIGNED <b>10-2-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>RONALD S. FLEISCHER</b>		22d. ADDRESS <b>1432 QUEENS CHAPEL Rd, Hyattsville</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct 5, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>ACT 4 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

1155

THE STATE OF TEXAS

1155

County of \_\_\_\_\_ State of \_\_\_\_\_

Know all men by these presents, \_\_\_\_\_

of the County of \_\_\_\_\_ State of \_\_\_\_\_

do hereby certify that \_\_\_\_\_

is the true and correct copy of \_\_\_\_\_

as the same appears from the \_\_\_\_\_

records of the \_\_\_\_\_

County of \_\_\_\_\_ State of \_\_\_\_\_

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Pr Geo</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>			c. LENGTH OF STAY IN lb <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mont Rainier Md</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>					d. STREET ADDRESS <u>14012 - 33rd</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Wayland</u> Last <u>BELLMAN</u>					4. DATE OF DEATH Month <u>10</u> - Day <u>14</u> Year <u>1960</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-26-1913</u>		9. AGE (In years last birthday) <u>47</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heavy Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Heating</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Oscar Bellman</u>					14. MOTHER'S M maiden name <u>Betha Wiles</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>158-1-1588</u>		17. INFORMANT <u>Henry Bellman</u> <u>4808 78th Pl Hyattsville Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>inst</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>19</u>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Dayton Watkins</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>DAYTON WATKINS</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-14-60</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-18-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln</u>			22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington D.C.</u>					24a. REC'D BY REGISTRAR <u>DATE OCT 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Friend</u>		

MEDICAL CERTIFICATION

(M)

(I)

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09





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please forward the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11753 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11658

1. PLACE OF DEATH e. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Largo</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Largo</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Central Avenue</u>				d. STREET ADDRESS <u>Central Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Pierce</u> Last <u>Bennett</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OF RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 25, 1923</u>	
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas Station Attendant Service Station</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>			
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John E. Bennett</u>				14. MOTHER'S MAIDEN NAME <u>Pierce</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>230-16-0307</u>			
17. INFORMANT <u>Anne Mildred Bennett</u>				Address <u>6104 Greenview</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis of the Liver</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>10-22-60</u>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 26, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO., Riverdale, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 25 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

1153

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1153

HEALTH DISTRICT

CHAMBERS CO., Riverdale, Md.  
Eaton, Co. 25, 1960 Cedar Hill Cemetery, Eastland, Maryland.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11754 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11659

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accokeek</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accokeek</b>			
c. LENGTH OF STAY IN 1b <b>35 Yrs.</b>				d. STREET ADDRESS <b>214 Livingston Road</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>214 Livingston Road</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EDWIN ANTHONY BLANDFORD</b>				4. DATE OF DEATH <b>October 11, 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 6, 1914</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender-Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Resturant</b>			
11. BIRTHPLACE (State or foreign country) <b>Picatway, Maryland.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Thomas Sidney Blandford</b>				14. MOTHER'S MAIDEN NAME <b>Emma Theresa Carroll</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW II</b>			
17. INFORMANT <b>Claude S. Blandford, Colmar Manor, Md.</b>				Address <b>3821 Newark Rd.,</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hernia bag and shoe</b> DUE TO (b) <b>shot gun wound of head</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self with a shot gun</b>			
20c. TIME OF INJURY Month, Day, Year <b>Oct 11 1960</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>on his farm accokeek Md</b>				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>October 11, 1960.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>10-14-60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>St Marys Cem</b>				22d. LOCATION (City, town, or country) (State) <b>Pensatemy Md</b>			
23. FUNERAL DIRECTOR <b>Hunt Funeral Home, Waldorf Md</b>				ADDRESS			
24a. REC'D BY REGISTRAR <b>OCT 13 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

1524

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10-10-1964

NOTION REPORT 2003

Thomas Library - 11410

October 11, 1960

THE CODE LIBRARY

1895

10-11-01

Wm. T. ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11694

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11660

Item 7 Prim 272 10-11-60 et

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 mos. 10 das.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedar Heights</b> d. STREET ADDRESS <b>902 64th Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>R.</b> Last <b>Boardley</b>		4. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1866</b>
9. AGE (In years lost birthday) <b>94</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>30</b> Min.	11. IF UNDER 24 HRS. Hours <b>30</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	
11. BIRTHPLACE (State or foreign country) <b>Calvert Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Boardley</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Gray</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Ernest Boardley</b>		Address <b>902 64th Ave., N.E. Wash. D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>6 months</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the Sigmoid Colon</b> <b>6 months</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 7, 19 60</b> to <b>Oct. 1 19 60</b> that (I) (we) last saw the deceased alive on <b>Oct. 1 19 60</b> , and that death occurred at <b>1:15 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Harold S. Tidler</b>		22b. DATE SIGNED <b>10/3/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Harold S. Tidler, M.D.</b>		22d. ADDRESS <b>8402 Fenton St., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-5-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Suitland Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Plummer</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	
ADDRESS <b>3015 12th St., N.E.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 5 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>John T. Rhines &amp; Co.</b>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

11695 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNIVERSITY PARK</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PRINCE GEORGES GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>6705 COLESVILLE RD.</b>			
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>D.</b> Last <b>Bodecker</b>				4. DATE OF DEATH Month <b>10</b> Day <b>20</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 6-1888</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGRAVER-RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BUREAU OF ENGRAVING</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL BODECKER</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT (DAUGHTER) <b>FAY CARLENE TILP</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arterio Sclerosis Generalized</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dayton Watkins</b> EXAMINER'S NAME (Type) <b>DAYTON O. WATKINS</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>10-21-60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10/24/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>				24a. REC'D BY REGISTRAR <b>Arthur S. Kneale</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneale</b>	

# 13402 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. EDUCATION</p>	
<p>9. PRESENT ADDRESS</p>		<p>10. DATE OF DEATH</p>	
<p>11. TIME OF DEATH</p>		<p>12. PLACE OF DEATH</p>	
<p>13. CAUSE OF DEATH</p>		<p>14. MANNER OF DEATH</p>	
<p>15. SIGNATURE OF EXAMINER</p>		<p>16. SIGNATURE OF WITNESS</p>	
<p>17. SIGNATURE OF CORONER</p>		<p>18. SIGNATURE OF JURY</p>	
<p>19. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>20. SIGNATURE OF CLERK</p>	
<p>21. SIGNATURE OF SHERIFF</p>		<p>22. SIGNATURE OF JAILER</p>	
<p>23. SIGNATURE OF DEPUTY SHERIFF</p>		<p>24. SIGNATURE OF DEPUTY JAILER</p>	
<p>25. SIGNATURE OF DEPUTY CLERK</p>		<p>26. SIGNATURE OF DEPUTY DISTRICT ATTORNEY</p>	
<p>27. SIGNATURE OF DEPUTY CORONER</p>		<p>28. SIGNATURE OF DEPUTY JURY</p>	
<p>29. SIGNATURE OF DEPUTY SHERIFF</p>		<p>30. SIGNATURE OF DEPUTY JAILER</p>	
<p>31. SIGNATURE OF DEPUTY CLERK</p>		<p>32. SIGNATURE OF DEPUTY DISTRICT ATTORNEY</p>	
<p>33. SIGNATURE OF DEPUTY CORONER</p>		<p>34. SIGNATURE OF DEPUTY JURY</p>	
<p>35. SIGNATURE OF DEPUTY SHERIFF</p>		<p>36. SIGNATURE OF DEPUTY JAILER</p>	
<p>37. SIGNATURE OF DEPUTY CLERK</p>		<p>38. SIGNATURE OF DEPUTY DISTRICT ATTORNEY</p>	
<p>39. SIGNATURE OF DEPUTY CORONER</p>		<p>40. SIGNATURE OF DEPUTY JURY</p>	
<p>41. SIGNATURE OF DEPUTY SHERIFF</p>		<p>42. SIGNATURE OF DEPUTY JAILER</p>	
<p>43. SIGNATURE OF DEPUTY CLERK</p>		<p>44. SIGNATURE OF DEPUTY DISTRICT ATTORNEY</p>	
<p>45. SIGNATURE OF DEPUTY CORONER</p>		<p>46. SIGNATURE OF DEPUTY JURY</p>	
<p>47. SIGNATURE OF DEPUTY SHERIFF</p>		<p>48. SIGNATURE OF DEPUTY JAILER</p>	
<p>49. SIGNATURE OF DEPUTY CLERK</p>		<p>50. SIGNATURE OF DEPUTY DISTRICT ATTORNEY</p>	
<p>51. SIGNATURE OF DEPUTY CORONER</p>		<p>52. SIGNATURE OF DEPUTY JURY</p>	
<p>53. SIGNATURE OF DEPUTY SHERIFF</p>		<p>54. SIGNATURE OF DEPUTY JAILER</p>	
<p>55. SIGNATURE OF DEPUTY CLERK</p>		<p>56. SIGNATURE OF DEPUTY DISTRICT ATTORNEY</p>	
<p>57. SIGNATURE OF DEPUTY CORONER</p>		<p>58. SIGNATURE OF DEPUTY JURY</p>	
<p>59. SIGNATURE OF DEPUTY SHERIFF</p>		<p>60. SIGNATURE OF DEPUTY JAILER</p>	
<p>61. SIGNATURE OF DEPUTY CLERK</p>		<p>62. SIGNATURE OF DEPUTY DISTRICT ATTORNEY</p>	
<p>63. SIGNATURE OF DEPUTY CORONER</p>		<p>64. SIGNATURE OF DEPUTY JURY</p>	
<p>65. SIGNATURE OF DEPUTY SHERIFF</p>		<p>66. SIGNATURE OF DEPUTY JAILER</p>	
<p>67. SIGNATURE OF DEPUTY CLERK</p>		<p>68. SIGNATURE OF DEPUTY DISTRICT ATTORNEY</p>	
<p>69. SIGNATURE OF DEPUTY CORONER</p>		<p>70. SIGNATURE OF DEPUTY JURY</p>	
<p>71. SIGNATURE OF DEPUTY SHERIFF</p>		<p>72. SIGNATURE OF DEPUTY JAILER</p>	
<p>73. SIGNATURE OF DEPUTY CLERK</p>		<p>74. SIGNATURE OF DEPUTY DISTRICT ATTORNEY</p>	
<p>75. SIGNATURE OF DEPUTY CORONER</p>		<p>76. SIGNATURE OF DEPUTY JURY</p>	
<p>77. SIGNATURE OF DEPUTY SHERIFF</p>		<p>78. SIGNATURE OF DEPUTY JAILER</p>	
<p>79. SIGNATURE OF DEPUTY CLERK</p>		<p>80. SIGNATURE OF DEPUTY DISTRICT ATTORNEY</p>	
<p>81. SIGNATURE OF DEPUTY CORONER</p>		<p>82. SIGNATURE OF DEPUTY JURY</p>	
<p>83. SIGNATURE OF DEPUTY SHERIFF</p>		<p>84. SIGNATURE OF DEPUTY JAILER</p>	
<p>85. SIGNATURE OF DEPUTY CLERK</p>		<p>86. SIGNATURE OF DEPUTY DISTRICT ATTORNEY</p>	
<p>87. SIGNATURE OF DEPUTY CORONER</p>		<p>88. SIGNATURE OF DEPUTY JURY</p>	
<p>89. SIGNATURE OF DEPUTY SHERIFF</p>		<p>90. SIGNATURE OF DEPUTY JAILER</p>	
<p>91. SIGNATURE OF DEPUTY CLERK</p>		<p>92. SIGNATURE OF DEPUTY DISTRICT ATTORNEY</p>	
<p>93. SIGNATURE OF DEPUTY CORONER</p>		<p>94. SIGNATURE OF DEPUTY JURY</p>	
<p>95. SIGNATURE OF DEPUTY SHERIFF</p>		<p>96. SIGNATURE OF DEPUTY JAILER</p>	
<p>97. SIGNATURE OF DEPUTY CLERK</p>		<p>98. SIGNATURE OF DEPUTY DISTRICT ATTORNEY</p>	
<p>99. SIGNATURE OF DEPUTY CORONER</p>		<p>100. SIGNATURE OF DEPUTY JURY</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 should be filed with the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11696

11696  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11662

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1 1/2 Hr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH Month <b>Oct.</b> Day <b>12</b> Year <b>19 60</b>				5. SEX <b>male</b> 6. COLOR OR RACE <b>Colored</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>Oct. 11, 1960</b>				9. AGE (In years lost birthday) yrs. <b>14</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Md.</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Patrick Herbert Harrison</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Boone</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>as above</b>			
17. INFORMANT <b>Mother</b>				Address <b>as above</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>762.5</b> IMMEDIATE CAUSE (a) <b>prematurity (15 oz)</b> DUE TO <b>atelectasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>atelectasis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 11</b> 19 <b>60</b> to <b>Oct. 12</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Oct. 11</b> 19 <b>60</b> and that death occurred at <b>3:15 AM</b> the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas A. Christensen</b>				22b. DATE SIGNED <b>10/12/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Thomas A. Christensen</b>				22d. ADDRESS <b>College Park, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>10-29-60</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Maryland</b>				23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Penn, Jr.</b>				25a. REC'D BY REGISTRAR <b>NOV 1 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Haines</b>							

2077181XVO



11038

11038



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11663  
Reg. Dist. No.

11745

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b Unk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 801 8th St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH H. BORNSTEIN		4. DATE OF DEATH Month Day Year OCTOBER 31 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> UNK <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Dec 1912
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY US Army	
11. BIRTHPLACE (State or foreign country) Mass		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unk		14. MOTHER'S MAIDEN NAME Unk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Personnel Records		Address Ft Geo G. Meade, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE Dayton O. Watkins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON O. WATKINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10			
22a. BURIAL, CREMATION, or other disposal (Specify) Removal		22b. DATE THEREOF 11/1/60	
22c. NAME OF CEMETERY OR CREMATORY Ford Funeral Chapel		22d. LOCATION (City, town, or county) (State) Chelsea Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE Carl D. Watkins		24b. REC'D BY REGISTRAR	
ADDRESS 6306 - Belair Rd, Baltimore - 6, Md		DATE NOV 3 '60	
		24c. REGISTRAR'S SIGNATURE Arthur S. Kraus	



## CERTIFICATE OF DEATH

Reg. Dist. No.

11755

11664

1. PLACE OF DEATH COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		c. LENGTH OF STAY IN 1b <b>4 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Hickory Hill Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALMA</b> First <b>ARENA</b> Middle <b>BOST</b> Last		4. DATE OF DEATH <b>Oct.</b> Month <b>17</b> Day <b>19</b> Year <b>60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 Mar. 09</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edwin Welsh</b>		14. MOTHER'S MAIDEN NAME <b>Mary A. Markward</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Terry N. Bost (Husband)</b> Address <b>Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>353.3</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>Epileptics</b> DUE TO (c) <b>Epilptics</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/12</b> , 19 <b>60</b> , to <b>10/17</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>10/12</b> , 19 <b>60</b> , and that death occurred at <b>6 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Hei K. Lee</b>		ADDRESS (Street, city or town, state) <b>Annapolis Rd Lanham Md.</b>	
PHYSICIAN'S NAME (Type) <b>HEI K. LEE</b>		DATE SIGNED <b>7732</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/20/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>Oct 24 '60</b>	
ADDRESS <b>Hyattsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11755

CERTIFICATE OF DEATH

11755

George, Prince George's

London

4 Years

London

Wickham Hill Ave.

Wickham Hill Ave.

17

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DEPT

DEPT

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London

21

25 Mar. 60

London

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George, Prince George's

no

George, Prince George's

George, Prince George's



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11665

Reg. Dist. No.

11741

Items 8,9 Filed 11-15-60 at

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District Heights</b>		c. LENGTH OF STAY IN lb <b>2 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2600 Rochelle Avenue</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District Heights</b> 23	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LUCILLE A. BRADBURY</b>		4. DATE OF DEATH Month Day Year <b>October 29, 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 18, 1914</b>
9. AGE (In years last birthday) <b>46 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Library Congress</b>	
11. BIRTHPLACE (State or foreign country) <b>Anderson S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Casper Bean</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Norma Bradbury (Daughter)</b>		Address <b>80th Ave. N. Forestville</b> In Law	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Hypertensive Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1 year</b> DUE TO <b>disuse</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dayton O. Watkins</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dayton O. Watkins</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>10/29/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 1st 60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington Nat'l</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros.</b>		ADDRESS <b>1661--Good Hope Rd., SE Washington 20 DC</b>	
24a. REC'D BY REGISTRAR <b>DATE NOV 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Death		6. Cause of Death		7. Manner of Death		8. Signature of Medical Examiner	
9. Signature of Coroner		10. Signature of Registrar		11. Signature of Physician		12. Signature of Nurse	
13. Signature of Undertaker		14. Signature of Burial Society		15. Signature of Cemetery		16. Signature of Funeral Home	
17. Signature of Mortician		18. Signature of Embalmer		19. Signature of Preparator		20. Signature of Assistant	
21. Signature of Assistant		22. Signature of Assistant		23. Signature of Assistant		24. Signature of Assistant	
25. Signature of Assistant		26. Signature of Assistant		27. Signature of Assistant		28. Signature of Assistant	
29. Signature of Assistant		30. Signature of Assistant		31. Signature of Assistant		32. Signature of Assistant	
33. Signature of Assistant		34. Signature of Assistant		35. Signature of Assistant		36. Signature of Assistant	
37. Signature of Assistant		38. Signature of Assistant		39. Signature of Assistant		40. Signature of Assistant	
41. Signature of Assistant		42. Signature of Assistant		43. Signature of Assistant		44. Signature of Assistant	
45. Signature of Assistant		46. Signature of Assistant		47. Signature of Assistant		48. Signature of Assistant	
49. Signature of Assistant		50. Signature of Assistant		51. Signature of Assistant		52. Signature of Assistant	
53. Signature of Assistant		54. Signature of Assistant		55. Signature of Assistant		56. Signature of Assistant	
57. Signature of Assistant		58. Signature of Assistant		59. Signature of Assistant		60. Signature of Assistant	
61. Signature of Assistant		62. Signature of Assistant		63. Signature of Assistant		64. Signature of Assistant	
65. Signature of Assistant		66. Signature of Assistant		67. Signature of Assistant		68. Signature of Assistant	
69. Signature of Assistant		70. Signature of Assistant		71. Signature of Assistant		72. Signature of Assistant	
73. Signature of Assistant		74. Signature of Assistant		75. Signature of Assistant		76. Signature of Assistant	
77. Signature of Assistant		78. Signature of Assistant		79. Signature of Assistant		80. Signature of Assistant	
81. Signature of Assistant		82. Signature of Assistant		83. Signature of Assistant		84. Signature of Assistant	
85. Signature of Assistant		86. Signature of Assistant		87. Signature of Assistant		88. Signature of Assistant	
89. Signature of Assistant		90. Signature of Assistant		91. Signature of Assistant		92. Signature of Assistant	
93. Signature of Assistant		94. Signature of Assistant		95. Signature of Assistant		96. Signature of Assistant	
97. Signature of Assistant		98. Signature of Assistant		99. Signature of Assistant		100. Signature of Assistant	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

11697 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										11666					
										Reg. Dist. No.					
1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN lb D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			62							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital					d. STREET ADDRESS 4104 Gallatin Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Harry First Middle Last Lamont Brickerton					4. DATE OF DEATH Month Day Year October 30, 19 60										
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 29, 1891		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Baker			11. BIRTHPLACE (State or foreign country) Washington D. C.			12. CITIZEN OF WHAT COUNTRY? U. S. A.						
13. FATHER'S NAME Harry D. Brickerton					14. MOTHER'S MAIDEN NAME Lordonia Scroggins										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Leslie H. Wood Address 2613 Blue Ridge Ave. Wheaton, Md.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease (c) Curious of liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH not years years					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF Nov 2, 1960		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D C	
23. FUNERAL DIRECTOR'S SIGNATURE F, Gasch's Sons Hyattsville, Md.						24a. REC'D BY REGISTRAR DATE NOV 3 '60		24b. REGISTRAR'S SIGNATURE Charles E. Hines							

11657

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11657

NAME OF DECEASED <b>JOHN J. BROWN</b>		AGE <b>45</b>		SEX <b>M</b>		RACE <b>W</b>		DATE OF DEATH <b>10/15/1915</b>		PLACE OF DEATH <b>100 N. ST. BOSTON</b>	
RESIDENCE <b>100 N. ST. BOSTON</b>		OCCUPATION <b>LABORER</b>		CAUSE OF DEATH <b>HEART DISEASE</b>		MANNER OF DEATH <b>NATURAL</b>		MEDICAL HISTORY <b>None</b>		POST-MORTEM EXAMINATION <b>None</b>	
SIGNATURE OF EXAMINER <b>J. G. McLaughlin</b>		TITLE <b>Medical Examiner</b>		DATE <b>10/15/1915</b>		PLACE <b>Boston</b>		COUNTY <b>Suffolk</b>		STATE <b>Mass.</b>	

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>6 MO.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HYATTSVILLE CONVALESCENT &amp; REST HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Addison</u> First <u>MONROE</u> Middle <u>Brock</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Benjamin Brock</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Inez Severe</u>		Address <u>daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>422.2</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>60</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>10-24</u> , 19 <u>60</u> , that I lost saw the deceased alive on <u>10-24</u> , 19 <u>60</u> , and that death occurred at <u>3 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leonard Hays</u>		ADDRESS (Street, city or town, state) <u>5201 Baltimore Ave Hyattsville Md.</u>	
PHYSICIAN'S NAME (Type) <u>Leonard Hays</u>		DATE SIGNED <u>Oct 26 '60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 27, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REC'D BY REGISTRAR <u>Oct 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11668

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>1 6612 Gude Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>-</u> Last <u>Bulle</u>				4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/3/1887</u>	
9. AGE (In years lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Latvia</u>	
13. FATHER'S NAME <u>Janis Bulle</u>				14. MOTHER'S MAIDEN NAME <u>Edite Cinats</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-48-2485</u>		17. INFORMANT <u>Decedent</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma, right lung</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/10</u> <u>11:05</u> to <u>10/27</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>10/27</u> <u>19 60</u> , and that death occurred at <u>P.</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Moe Weiss</u>				M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/27/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>				22d. ADDRESS <u>Glenn Dale Hospital Glenn Dale, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>10/29/60</u>		23b. DATE THEREOF <u>10/29/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. N. Harris Co</u>				ADDRESS <u>2901-x 48th St. N.W. Wash D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 1 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

1100\*

CERTIFICATE OF DEATH

11578

(M)



(1)



*[Faint, illegible handwritten text at the bottom of the page, possibly a signature or address.]*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11678

CERTIFICATE OF DEATH

11669

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor Conv Home		d. STREET ADDRESS 404 - H St N.E.	
3. NAME OF DECEASED (Type or print) DENIS First C. Middle BURCH Last		4. DATE OF DEATH October 11, 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 27-1877
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		9b. KIND OF BUSINESS OR INDUSTRY Men's Furnishings	9. AGE (In years last birthday) yrs. 83
10a. BIRTHPLACE (State or foreign country) Chas Co. Md.		11. BIRTHPLACE (State or foreign country) Chas Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Henry A. Burch	
14. MOTHER'S MAIDEN NAME Susan R Burch		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT S. M. Bernadette Joseph	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of The Prostate with Metastasis DUE TO to the Brain Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 23 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 20, 1950, to Oct. 11, 1960, that I last saw the deceased alive on Oct. 10, 1960, and that death occurred at 6:05 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Collins		ADDRESS (Street, city or town, state) 322- H. Street, N.E. DATE SIGNED Oct. 11, 1960	
PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.		Washington 2, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Oct 14 1960		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS 300-4 St N.E.	
24a. REC'D BY REGISTRAR DATE OCT 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wash b. COUNTY DC	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		d. STREET ADDRESS 203-Ky. Ave. D.E.	
3. NAME OF DECEASED (Type or print) First Middle Last Emma Cadann		4. DATE OF DEATH Month Day Year Oct. 22, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 JUNE 1868 92 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED DEPT STORE		10b. KIND OF BUSINESS OR INDUSTRY DEPT STORE	
11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE HAYES		14. MOTHER'S MAIDEN NAME MARY BROWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT George E. Cadann		Address Wash. AC 2901 Conn Ave N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Acute Congestive Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Heart Disease (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 18 hours 5 yrs. 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-11, 1960, to 10-22, 1960, that I last saw the deceased alive on 10-19, 1960, and that death occurred at 7a. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Herbert S. Gates M.D.			
PHYSICIAN'S NAME (Type) Herbert S. Gates		815 E. Capt. St. Wash. AC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/24/60	22c. NAME OF CEMETERY OR CREMATORY Congressional	22d. LOCATION (City, town, or county) (State) Washington DC
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co		ADDRESS 517-11 Ch St. SE Wash. AC	
24a. REC'D BY REGISTRAR DATE OCT 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11758

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11671

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 1015 M. St., N. W.			
3. NAME OF DECEASED (Type or print) First Eligio Middle - Last Chiochetti				4. DATE OF DEATH Month 10 Day 12 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> but separated <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/20/1893	
9. AGE (In years lost birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper sales		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Felice Chicchetti				14. MOTHER'S MAIDEN NAME Angela Buzaniono			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-05-8875		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe anemia, etiology undetermined; chronic alcoholism						INTERVAL BETWEEN ONSET AND DEATH 5 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/22/1960 to 10/12/1960, that (I) (we) last saw the deceased alive on 10/12/1960, and that death occurred at A. M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 10/12/60		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.	
22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.				22e. REC'D BY REGISTRAR DATE OCT 18 '60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10/14/60		23c. NAME OF CEMETERY OR CREMATORY D.C. Morgue		23d. LOCATION (City, town, or county) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Moe Weiss				25. REGISTRAR'S SIGNATURE			

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11071

CERTIFICATE OF DEATH

11728

Blank form area with faint horizontal lines and ghosted text from the reverse side.

Handwritten notes at the bottom of the page, including the name "Wm. J. [illegible]" and other illegible text.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the funeral director, and in any event, within 72 hours after death.

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STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11673

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> c. LENGTH OF STAY IN 1b <b>Washington, D.C.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR SANITARIUM</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>2700 Conn. Ave. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARGARET C. COLUMBUS</b>		4. DATE OF DEATH Month Day Year <b>10 18 1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/15/81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bureau of Engraving and Printing</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>
13. FATHER'S NAME <b>William F. Columbus</b>		14. MOTHER'S MAIDEN NAME <b>Martha Gromley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>442X</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. <b>Chronic Cardio-Vascular Disease</b> DUE TO <b>8 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death 10 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>7 Oct 60 / 8 Oct 60</b>	
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>7 Oct 60</b> to <b>19 Oct 60</b> , that (I) <del>(the)</del> last saw the deceased alive on <b>19 Oct 60</b> , and that death occurred at <b>19 Oct 60</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert C. Haile</b>		22b. DATE <b>19 Oct 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert C. Haile</b>		22d. ADDRESS <b>35 New York Ave. N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>10/21/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 20 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			



07-00 0:11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

11693

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11674

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Edward Constantine</b>		4. DATE OF DEATH Month <b>Oct 11,</b> Day <b>19</b> Year <b>60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 25, 1898</b>
9. AGE (In years last birthday) <b>62</b>		10. IF UNDER 1 YEAR Months <b>62</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cabinet maker</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William C Constantine</b>		14. MOTHER'S MAIDEN NAME <b>Mary E Daniels</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217 03 6760</b>	
17. INFORMANT <b>Gertrude C Vermeule</b>		Address <b>Hyattsville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>30 mins</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1940</b> to <b>Oct 11, 1960</b> , that I last saw the deceased alive on <b>Oct 7, 1960</b> , and that death occurred at <b>19</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leonard Hays</b>		DATE SIGNED <b>10-11-60</b>	
PHYSICIAN'S NAME (Type) <b>Leonard Hays</b>		<b>Hyattsville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 13, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland.</b>	
24a. REC'D BY REGISTRAR <b>OCT 13 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

1163

CERTIFICATE OF DEATH

1163

State of Illinois, County of Cook, City of Chicago, I, the undersigned, being a duly qualified physician, do hereby certify that

the within and foregoing is a true and correct copy of the original as the same appears from the records of the

City of Chicago

Office of the Registrar of Deaths

City of Chicago, Illinois, this 1st day of January, 1900.

Witness my hand and the seal of said City, at Chicago, Illinois, this 1st day of January, 1900.

Attest: My hand and the seal of said City, at Chicago, Illinois, this 1st day of January, 1900.

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Attest: My hand and the seal of said City, at Chicago, Illinois, this 1st day of January, 1900.

Attest: My hand and the seal of said City, at Chicago, Illinois, this 1st day of January, 1900.

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Attest: My hand and the seal of said City, at Chicago, Illinois, this 1st day of January, 1900.

Attest: My hand and the seal of said City, at Chicago, Illinois, this 1st day of January, 1900.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an delay is necessary, please state the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

11755  
DISTRICT OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11675  
MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OXEN HILL</b> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>POTOMAC RIVER</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>ALEXANDRIA</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ALEXANDRIA</b> d. STREET ADDRESS <b>902 PRINCE ST.</b>				6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Richard Eugene Crump</b>				4. DATE OF DEATH Month <b>Oct</b> Day <b>4</b> Year <b>1960</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>21 MAY 1930</b>		9. AGE (In years last birthday) <b>30</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SERVICE MAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>EXTERMINATING</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>MORACE W. CRUMP</b>				14. MOTHER'S MAIDEN NAME <b>MARY F. HARLOW</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>1952 - 1954</b>				16. SOCIAL SECURITY NO. <b>1952 - 1954</b>		17. INFORMANT <b>RAYMOND L. CRUMP (BRO)</b> Address <b>6510 NEWTON ST. HYATTSVILLE, MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>850X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>heroining</b> (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell 700 a boat</b>					
20c. TIME OF INJURY Month, Day, Year <b>10-1 1960</b> Hour <b>1</b> a.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Potomac River</b>		20f. (City or town) <b>Oxon Hill</b> (County) <b>Pg</b> (State) <b>Wm</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>James I. Boyd</b>				M.D. <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10-4-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5 Oct 60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Alexandria National</b>		22d. LOCATION (City, town, or country) (State) <b>Alexandria, Virginia</b>			
23. FUNERAL DIRECTOR <b>Cunningham Funeral Home Inc.</b> ADDRESS <b>Alex., Va.</b>				24a. REC'D BY REGISTRAR <b>OCT 6 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>			

MEDICAL CERTIFICATION

1177

MEDICAL EXAMINER CERTIFICATE OF DEATH

1177

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CERTIFICATE OF DEATH

Reg. Dist. No.

11688

11676

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt Rainier Md</b>				c. LENGTH OF STAY IN lb <b>46 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3301 Bunker Hill Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William Thomas</b> Middle <b>Daniels</b> Last				4. DATE OF DEATH Month <b>October</b> Day <b>5,</b> Year <b>19 60-</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6, 1877</b>		9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min.	IF UNDER 24 HRS. Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Edward F Daniels</b>				14. MOTHER'S MAIDEN NAME <b>Clara Reacou</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212145234</b>		INFORMANT Address <b>Lottie Daniels Mt Rainier Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary infarction</b> DUE TO <b>Adrenosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adrenosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>home</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 7</b> , 1959, to <b>Oct 5</b> , 1960, that I last saw the deceased alive on <b>Oct 5</b> , 1960, and that death occurred at <b>4p</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>George Hageage M.D. 3717-38th Ave 10-5-60</b>							
ACTUAL SIGNATURE <b>George Hageage</b>		PHYSICIAN'S NAME (Type) <b>George Hageage Cottage City Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/8/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 13 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kruza</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G273 10-18-60 et

## CERTIFICATE OF DEATH

11760

11677

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Pr. Geo's</b></span>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glassmanor</b>			c. LENGTH OF STAY IN 1b <b>6 Months</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glassmanor</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <b>317- Winthrop Street S.E.</b>				d. STREET ADDRESS <b>317- Winthrop Street S.E.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First <b>ZORA</b></span> <span>Middle</span> <span>Last <b>DAVIS</b></span> </div>				<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>Month <b>October</b></span> <span>Day <b>9</b></span> <span>Year <b>19 60</b></span> </div>									
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Nov. 22<del>nd</del></b> 1892		<b>9. AGE</b> (In years last birthday) yrs. <b>67</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Domestic</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>West Virginia</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>John M. Gabbert</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Jeanette Hughes</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)		<b>INFORMANT</b> Address <b>Mrs. Beatrice P. Geib. Same as # 2.</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>metastatic carcinoma</b>  <b>170X</b> DUE TO          Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u>lying cause lost. (b) <b>of breast</b> DUE TO (c)       </div>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>years.</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify</b> that I attended the deceased from <b>Sept. 1960</b> to <b>Oct. 9, 1960</b> , that I last saw the deceased alive on <b>Oct 9, 1960</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.													
<b>ACTUAL SIGNATURE</b> <i>Herbert Wisotsky</i> M.D.						<b>ADDRESS</b> (Street, city or town, state) <b>DATE SIGNED</b> <b>101- Audrey Lane S.E. Oxon Hill, Md. 10/10/1960</b>							
<b>PHYSICIAN'S NAME (Type)</b> <b>HERBERT WISOTSKY</b>						<b>101- Audrey Lane S.E. Oxon Hill, Md.</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>Oct. 12-1960</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Washington National</b>				<b>22d. LOCATION</b> (City, town, or county) (State) <b>Suitland, Maryland</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ADDRESS</b> <i>Simmons Brothers</i> <b>1661- Good Hope Rd. S.E. Washington, D.C.</b>													
<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>OCT 11 '60</b>						<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Kraus</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11077

CERTIFICATE OF DEATH

11780

1. Name of deceased: [illegible] 2. Sex: [illegible] 3. Age: [illegible]

4. Date of death: [illegible] 5. Place of death: [illegible]

6. Cause of death: [illegible]

7. Signature of physician: [illegible]

8. Signature of registrar: [illegible]

9. Signature of informant: [illegible]

10. Date of registration: [illegible]

11. Place of registration: [illegible]

12. Signature of registrar: [illegible]

13. Signature of informant: [illegible]

14. Date of registration: [illegible]

15. Place of registration: [illegible]

16. Signature of registrar: [illegible]

17. Signature of informant: [illegible]

18. Date of registration: [illegible]

19. Place of registration: [illegible]

20. Signature of registrar: [illegible]

21. Signature of informant: [illegible]

11678

# CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Prince Georges		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cheverly		c. LENGTH OF STAY IN 1b 27 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle	
Jennie		M		Last	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None		Store		Niagara Falls, N.Y.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Alfred Harrison		Amelia Lee		U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Frederick M. DeWaters, son	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
157X		DUE TO		1 mos	
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.		(b)		3 mos	
DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Month, Day, Year 19		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/18/60 to 10/15/60 that (I) (we) last saw the deceased alive on 10/15/60, and that death occurred at 3:30 AM from the causes and on the date stated above.		22a. SIGNATURE Dr. Norman Comeau, M.D.		22b. DATE 10/15/60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Mt. Rainier, Md.		22e. STAFF PHYS. SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
Burial		10/18/60		Fort Lincoln	
24. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Nalley's Funeral Home		DATE OCT 19 '60		Arthur L. P... ..	

11038

STATE DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

11003

*[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]*

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

(2)

(2)

VS. A15ME  
5M 7/59

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>11761</p> <p><b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b></p> <p>11679</p> </div> </div>												
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> <span style="float: right;">MARYLAND</span>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b> d. STREET ADDRESS <b>4892 Sunset Lane</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Suitland</b> c. LENGTH OF STAY IN 1b <b>22 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eastern Lane</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Timothy</b> Middle <b>Lee</b> Last <b>Dooley</b>						<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>13th</b> Year <b>19 60</b>						
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>January 29-1892</b>		<b>9. AGE</b> (In years last birthday) <b>68</b> yrs. <div style="display: flex;"> <div>IF UNDER 1 YEAR</div> <div>IF UNDER 24 HRS.</div> </div>				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Gardner</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>C.L.Jenkins</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Burke Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				
<b>13. FATHER'S NAME</b> <b>Joseph Dooley</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service) <b>None</b>						<b>16. SOCIAL SECURITY NO.</b> <b>213-24-2842</b>						
<b>17. INFORMANT</b> <b>Evelyn L. Harkness</b>						<b>Address</b> <b>1207 Brooke Drive Rockville, Maryland</b>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex;"> <div style="flex: 1;"> <p><b>PART I. DEATH WAS CAUSED BY:</b></p> <p><b>IMMEDIATE CAUSE (a)</b> <b>Coronary Thrombosis</b></p> <p><b>420.1</b> DUE TO</p> <p><b>(b) Coronary Atherosclerosis</b></p> <p><b>(c) Cardio vascular Renal disease</b></p> </div> <div style="flex: 1;"> <p><b>INTERVAL BETWEEN ONSET AND DEATH</b></p> </div> </div>												
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>												
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)								
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
<b>ACTUAL SIGNATURE</b> <i>James I Boyd</i>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						
<b>EXAMINER'S NAME (Type)</b> <b>James I Boyd</b>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>						
						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						
						<b>DATE SIGNED</b> <b>10 - 14 - 60</b>						
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>Oct 17, 1960</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cemetery</b>		<b>22d. LOCATION (City, town, or country)</b> <b>Suitland, Maryland</b>				
<b>23. FUNERAL DIRECTOR</b> <b>W.W. Chambers Co.</b>						<b>ADDRESS</b> <b>517 11th St. S.E. Wash. D.C.</b>		<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Hanks</i>		
						<b>DATE</b> <b>OCT 19 '60</b>						



W. Chambers Co. 517 11th St. S.W. Wash. D.C.

James I. Boyd

19 - 11 - 60

x

x

x

Cardio vascular renal disease

Coronary Atherosclerosis

Coronary Thrombosis

None

213-24-28-2 Evelyn L. Harkness  
Rockville, Maryland

1807 Brooke Drive  
Rockville, Maryland

Joseph Dooley

Unknown

Gardner

G.I. Jenkins

Burke Virginia

U.S.A.

Male White

x

January 27-1898 68

Timothy

Lee

Dooley

October 19th 60

Eastern Lane

1892 Summit Lane

Scotland

22 Yorks

Scotland

Prince George

Maryland

Prince George

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11680

Reg. Dist. No.

11762

1. PLACE OF DEATH COUNTY <b>Pr. Geo.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>S.E.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>		c. LENGTH OF STAY IN 1b <b>2 Hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5353 DORR Pine St.</b>				d. STREET ADDRESS <b>1710 Mass. S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Joseph</b> Middle <b>Westley</b> Last <b>Douglas</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>27</b> , Year <b>19 60</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/23/08</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>		11. BIRTHPLACE (State or foreign country) <b>Ma.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Maltamore H. Douglass</b>		14. MOTHER'S MAIDEN NAME <b>Daisy L. Douglass</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Douglas</b> Address <b>Carroll H. Douglass (Brother) Same As # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Lacerations</b> DUE TO <b>976X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Compound Fracture Skull inst</b> DUE TO <b>Gunshot wound Skull</b> (c) <b>Gunshot wound Skull</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dayton O Watkins</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dayton O Watkins</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>18-27-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>10/31/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wash Nat Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Wm Lee's Sons &amp; Co</b> ADDRESS <b>300-4th St N.E.</b>				24a. REC'D BY REGISTRAR <b>OCT 31 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



## CERTIFICATE OF DEATH

11681

Reg. Dist. No.

11763

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Croom</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---				d. STREET ADDRESS ---			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Matthew</b> Last <b>Duley</b>				4. DATE OF DEATH Month <b>October</b> Day <b>17</b> Year <b>1960.</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 27, 1939</b>		9. AGE (In years last birthday) <b>20</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Bennett Duley</b>				14. MOTHER'S MAIDEN NAME <b>Althea Beall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Bennett Duley-</b> Address <b>Same as Item #2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial Pressure</b> <b>223x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cranio-pharyngoma</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs</b> <b>Life</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar</b> , 19 <b>52</b> , to <b>17 Oct</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Sept 1</b> , 19 <b>60</b> , and that death occurred at <b>6:05 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Upper Marlboro, Maryland</b> DATE SIGNED <b>10/17/60</b>							
ACTUAL SIGNATURE <b>R. B. Sasscer</b> M.D.							
PHYSICIAN'S NAME (Type) <b>R. B. Sasscer, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/20/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-Upper Marlboro,</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11764

CERTIFICATE OF DEATH

Reg. Dist. No.

11682

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillside</b>				c. LENGTH OF STAY IN 1b <b>1 year</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Forestville Nursing Home</b>				d. STREET ADDRESS <b>1213- 61st Street S.E. Place SE</b>			
3. NAME OF DECEASED (Type or print) <b>AUSTIN H. DUNWOODY</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>16th</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 1878</b>	9. AGE (In years last birthday) yrs. <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Worker</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. of A.</b>	
13. FATHER'S NAME <b>Dunwoody, John A.</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Quar. Corps Spanish-Am.</b>		16. SOCIAL SECURITY NO. <b>(Lost)</b>		INFORMANT Address <b>Silco L. Alvarez, 1213 61'st Place, Hillside, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Liver</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>* * *</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 2, 1960</b> to <b>October 16, 1960</b> , that I last saw the deceased alive on <b>October 15, 1960</b> , and that death occurred at <b>4:35 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walcutt W. Gibson</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>4340 St. Barnabas Rd., Washington Oct. 17, 1960</b> <b>22, D.C.</b>					
PHYSICIAN'S NAME (Type) <b>Walcutt W. Gibson, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 21st 60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bruington Bap. Church Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Bruington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Seawans Bass</b>				ADDRESS <b>1661- Good Hope Rd. S.E. Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 21 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			





11683

## CERTIFICATE OF DEATH

Reg. Dist. No.

11680

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HYATTSVILLE NURSING HOME</u>				d. STREET ADDRESS <u>1331 14th Pl. N.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>RUBY</u> Middle <u>F.</u> Last <u>EDELEN</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 11, 1872</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Bonell</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN IDA. BONELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CARL A. EDELEN</u>		Address <u>1440 Rock Creek Ford Rd. M.D.C. RA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept. 9</u> , 19 <u>60</u> , to <u>Oct. 15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct. 14</u> , 19 <u>60</u> , and that death occurred at <u>9:54 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>W. H. Clements</u> M.D.				<u>6001-35th Ave</u> <u>10/15/60</u>			
PHYSICIAN'S NAME (Type) <u>William H Clements</u>				<u>Hyattsville Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-18-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers &amp; Co. Riverdale, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registr. or prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, and page 4 with the registrar, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11700

11684

1. PLACE OF DEATH a. COUNTY <i>Pr Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Pr Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West Linton Hills 36</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Geo General</i>		d. STREET ADDRESS <i>7765 Emerson</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>DONNA MARIE ENGLE</i>		4. DATE OF DEATH Month Day Year <i>Oct 3 19 60</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 18 60</i>
9. AGE (In years last birthday) <i>1 10</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Herbert Engle</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Cahn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Barbara Engle</i> Address <i>7765 Emerson</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Dayton Watkins</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>DAYTON OWATKINS</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>10-9-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 5, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Port Lincoln Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Bladensburg, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers</i> ADDRESS <i>80 Riverdale, Md</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	
24b. REGISTRAR'S SIGNATURE		DATE <i>OCT 7 '60</i>	

2077285XV5

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11700

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF BIRTH <i>Jan 15, 1925</i>		6. PLACE OF BIRTH <i>Baltimore, Md.</i>	
7. MARITAL STATUS <i>Married</i>		8. OCCUPATION <i>Teacher</i>	
9. RESIDENCE <i>123 Main St., Baltimore, Md.</i>		10. DECEASED AT HOME <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
11. CAUSE OF DEATH <i>Myocardial Infarction</i>		12. MANNER OF DEATH <i>Natural</i>	
13. SIGNATURE OF EXAMINER <i>[Signature]</i>		14. DATE <i>Jan 20, 1970</i>	
15. SIGNATURE OF WITNESS <i>[Signature]</i>		16. DATE <i>Jan 20, 1970</i>	
17. SIGNATURE OF CORONER <i>[Signature]</i>		18. DATE <i>Jan 20, 1970</i>	
19. SIGNATURE OF JURY <i>[Signature]</i>		20. DATE <i>Jan 20, 1970</i>	
21. SIGNATURE OF JURY <i>[Signature]</i>		22. DATE <i>Jan 20, 1970</i>	
23. SIGNATURE OF JURY <i>[Signature]</i>		24. DATE <i>Jan 20, 1970</i>	
25. SIGNATURE OF JURY <i>[Signature]</i>		26. DATE <i>Jan 20, 1970</i>	
27. SIGNATURE OF JURY <i>[Signature]</i>		28. DATE <i>Jan 20, 1970</i>	
29. SIGNATURE OF JURY <i>[Signature]</i>		30. DATE <i>Jan 20, 1970</i>	
31. SIGNATURE OF JURY <i>[Signature]</i>		32. DATE <i>Jan 20, 1970</i>	
33. SIGNATURE OF JURY <i>[Signature]</i>		34. DATE <i>Jan 20, 1970</i>	
35. SIGNATURE OF JURY <i>[Signature]</i>		36. DATE <i>Jan 20, 1970</i>	
37. SIGNATURE OF JURY <i>[Signature]</i>		38. DATE <i>Jan 20, 1970</i>	
39. SIGNATURE OF JURY <i>[Signature]</i>		40. DATE <i>Jan 20, 1970</i>	
41. SIGNATURE OF JURY <i>[Signature]</i>		42. DATE <i>Jan 20, 1970</i>	
43. SIGNATURE OF JURY <i>[Signature]</i>		44. DATE <i>Jan 20, 1970</i>	
45. SIGNATURE OF JURY <i>[Signature]</i>		46. DATE <i>Jan 20, 1970</i>	
47. SIGNATURE OF JURY <i>[Signature]</i>		48. DATE <i>Jan 20, 1970</i>	
49. SIGNATURE OF JURY <i>[Signature]</i>		50. DATE <i>Jan 20, 1970</i>	
51. SIGNATURE OF JURY <i>[Signature]</i>		52. DATE <i>Jan 20, 1970</i>	
53. SIGNATURE OF JURY <i>[Signature]</i>		54. DATE <i>Jan 20, 1970</i>	
55. SIGNATURE OF JURY <i>[Signature]</i>		56. DATE <i>Jan 20, 1970</i>	
57. SIGNATURE OF JURY <i>[Signature]</i>		58. DATE <i>Jan 20, 1970</i>	
59. SIGNATURE OF JURY <i>[Signature]</i>		60. DATE <i>Jan 20, 1970</i>	
61. SIGNATURE OF JURY <i>[Signature]</i>		62. DATE <i>Jan 20, 1970</i>	
63. SIGNATURE OF JURY <i>[Signature]</i>		64. DATE <i>Jan 20, 1970</i>	
65. SIGNATURE OF JURY <i>[Signature]</i>		66. DATE <i>Jan 20, 1970</i>	
67. SIGNATURE OF JURY <i>[Signature]</i>		68. DATE <i>Jan 20, 1970</i>	
69. SIGNATURE OF JURY <i>[Signature]</i>		70. DATE <i>Jan 20, 1970</i>	
71. SIGNATURE OF JURY <i>[Signature]</i>		72. DATE <i>Jan 20, 1970</i>	
73. SIGNATURE OF JURY <i>[Signature]</i>		74. DATE <i>Jan 20, 1970</i>	
75. SIGNATURE OF JURY <i>[Signature]</i>		76. DATE <i>Jan 20, 1970</i>	
77. SIGNATURE OF JURY <i>[Signature]</i>		78. DATE <i>Jan 20, 1970</i>	
79. SIGNATURE OF JURY <i>[Signature]</i>		80. DATE <i>Jan 20, 1970</i>	
81. SIGNATURE OF JURY <i>[Signature]</i>		82. DATE <i>Jan 20, 1970</i>	
83. SIGNATURE OF JURY <i>[Signature]</i>		84. DATE <i>Jan 20, 1970</i>	
85. SIGNATURE OF JURY <i>[Signature]</i>		86. DATE <i>Jan 20, 1970</i>	
87. SIGNATURE OF JURY <i>[Signature]</i>		88. DATE <i>Jan 20, 1970</i>	
89. SIGNATURE OF JURY <i>[Signature]</i>		90. DATE <i>Jan 20, 1970</i>	
91. SIGNATURE OF JURY <i>[Signature]</i>		92. DATE <i>Jan 20, 1970</i>	
93. SIGNATURE OF JURY <i>[Signature]</i>		94. DATE <i>Jan 20, 1970</i>	
95. SIGNATURE OF JURY <i>[Signature]</i>		96. DATE <i>Jan 20, 1970</i>	
97. SIGNATURE OF JURY <i>[Signature]</i>		98. DATE <i>Jan 20, 1970</i>	
99. SIGNATURE OF JURY <i>[Signature]</i>		100. DATE <i>Jan 20, 1970</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/55

11701  
11685  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL or nearest town) <b>Chesley</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b> <b>45</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>4541 Banner St.,</b> <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charlotte</b> <b>First</b> <b>Evans</b> <b>Last</b>				4. DATE OF DEATH <b>Oct.</b> <b>25</b> <b>1960</b> <b>Month</b> <b>Day</b> <b>Year</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 13, 1960</b>	
9. AGE (In years lost birthday) <b>5</b> <b>yrs.</b>		IF UNDER 1 YEAR <b>5</b> <b>Months</b>		IF UNDER 24 HRS. <b>5</b> <b>Days</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>							
13. FATHER'S NAME <b>Windsor B. Shields Evans</b>				14. MOTHER'S MAIDEN NAME <b>Louise Crawford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mother</b> <b>Address</b> <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstatal Pneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Oct. 25, 1960</b> <b>6:35A</b> <b>to Oct. 25, 1960</b>				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 25, 1960</b> to <b>Oct. 25, 1960</b> , that (I) (we) last saw the deceased alive on <b>Oct. 25, 1960</b> , and that death occurred at <b>6:35A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Dayton O. Watkins</b>				22b. PHYSICIAN'S NAME (Type) <b>Dr. Dayton O. Watkins</b>		22c. ADDRESS <b>5304 Annapolis Rd. Bladensburg, Md.</b>	
22d. DATE <b>10/26/60</b>				22e. SIGNED <b>10/26/60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>10-27-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>	
23d. LOCATION (City, town, or county) <b>Md.</b>				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Sant John</b> <b>4804 So. Cal. N.W.</b>				25a. REC'D BY REGISTRAR <b>OCT 31 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kious</b>	

2077246XV3





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG273 10-14-60 et

## CERTIFICATE OF DEATH

11686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pr. George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Hgts. 27</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#822 57th Ave.</u>		d. STREET ADDRESS <u>822 57th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Isa</u> Middle <u>A.</u> Last <u>Gainer</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-91</u>
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>1</u> Min. <u>15</u>	IF UNDER 24 HRS. Months <u>1</u> Days <u>14</u> Hours <u>1</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Randall</u>		14. MOTHER'S MAIDEN NAME <u>Ladie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-16-0596</u>	
17. INFORMANT <u>Joseph H. Gainer</u>		Address <u>822-57th Ave. Capitol Heights, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident - massive</u> DUE TO <u>331</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>- 4/5</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Myelomatosis, cystitis - Complete heart Hemiplegia 20 YRS 6 years Ago</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>60</u> to <u>10/4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9/27</u> , 19 <u>60</u> , and that death occurred at <u>6:59 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Allen</u>		ADDRESS (Street, city or town, state) <u>4400 Bowen Road, S.E., D.C.</u> DATE SIGNED <u>10/4/60</u>	
PHYSICIAN'S NAME (Type) <u>Thomas F. Guilan</u>		<u>4400 Bowen Rd. S.E.</u>	
22a. BURIAL-CREATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10-7-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u> ADDRESS <u>517-11th St. S.E.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 7 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

CERTIFICATE OF DEATH

11588

1. NAME OF DECEASED <b>JOHN J. HENRY</b>		2. SEX <b>MALE</b>		3. AGE <b>68</b>	
4. DATE OF DEATH <b>NOV 10 1958</b>		5. TIME OF DEATH <b>10:00 AM</b>		6. PLACE OF DEATH <b>HOME</b>	
7. STREET ADDRESS <b>1234 E. BALTIMORE ST.</b>		8. CITY <b>BALTIMORE</b>		9. STATE <b>MARYLAND</b>	
10. ZIP CODE <b>21201</b>		11. COUNTY <b>BALTIMORE</b>		12. DISTRICT <b>11</b>	
13. OCCUPATION <b>RETIRED</b>		14. CAUSE OF DEATH <b>HEART DISEASE</b>		15. MANNER OF DEATH <b>NATURAL</b>	
16. MEDICAL HISTORY <b>NO</b>		17. PREVIOUS ILLNESS <b>NO</b>		18. SURGICAL HISTORY <b>NO</b>	
19. MEDICAL ATTENDANCE <b>NO</b>		20. NURSING ATTENDANCE <b>NO</b>		21. OTHER ATTENDANCE <b>NO</b>	
22. SIGNATURE OF DECEASED <b>JOHN J. HENRY</b>		23. SIGNATURE OF WITNESS <b>JOHN J. HENRY</b>		24. SIGNATURE OF PHYSICIAN <b>JOHN J. HENRY</b>	
25. SIGNATURE OF REGISTRAR <b>JOHN J. HENRY</b>		26. SIGNATURE OF CLERK <b>JOHN J. HENRY</b>		27. SIGNATURE OF JUDGE <b>JOHN J. HENRY</b>	

RECEIVED  
BALTIMORE  
NOV 10 1958

11765

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11687

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN 1b 6 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2506- Keating Street S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT H. GASS		4. DATE OF DEATH Oct. 14th 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29- 1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY St. Elizabeth Hosp	
11. BIRTHPLACE (State or foreign country) St. Mary's Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Gass		14. MOTHER'S MAIDEN NAME Maria Harden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT Mrs. Anna M. Gass. Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2.27X mesothelioma lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-15-46, 19, to 10-14-60, 19, that I last saw the deceased alive on 10-13-60, 19, and that death occurred at 4 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John B Fegan M.D.		ADDRESS (Street, city or town, state) 2210 hickory ave SE DATE SIGNED Wash DC	
PHYSICIAN'S NAME (Type) JOHN B FEGAN H.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 17- 1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers		ADDRESS 1661- Good Hope Rd. SE Washington 20, D.C.	
24a. REC'D BY REGISTRAR DATE OCT 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11687

CERTIFICATE OF DEATH

11687

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
11766					11688					
CERTIFICATE OF DEATH										
1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY IN 1b 8 months and 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital					d. STREET ADDRESS 906 N.Y. Ave., NW (DC Annex)			e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
3. NAME OF DECEASED (Type or print) First Middle Last Claude E. Gilley					4. DATE OF DEATH Month Day Year 10 26 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/27/03		9. AGE (In years lost birthday) yrs. 57		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Worked for Mr. Hicks?		11. BIRTHPLACE (State or foreign country) South Carolina			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Walker					14. MOTHER'S MAIDEN NAME Addie Mary Hollenbeck					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 241-05-5181		17. INFORMANT Decedent			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma, right lung 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 2 yrs.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2/21/1960, to 10/26/1960, that (I) (we) last saw the deceased alive on 10/26/1960, and that death occurred at 8:40 M. from the causes and on the date stated above.										
22a. SIGNATURE Moe Weiss					22b. DATE SIGNED 10/26/60		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.			
22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF 10/27/60		23c. NAME OF CEMETERY OR CREMATORY Reidsville, N. C.			23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home					ADDRESS 816-24 St. NE.		25a. REC'D BY REGISTRAR DATE OCT 31 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



11002

11002

CERTIFICATE OF ANALYSIS

Blank certificate form with faint horizontal lines and a large circular stamp on the right side.

11767

## CERTIFICATE OF DEATH

Reg. Dist. No.

11689

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. BRENTWOOD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. BRENTWOOD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>4541 BANNER</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>GILMORE</u>				4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-1873</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAR CLEANER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>Rock Hill S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BEN GILMORE</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>718-18-0355</u>		17. INFORMANT <u>Louise EVANS</u>		Address <u>4541-BANNER ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis (Heart Failure)</u> DUE TO <u>241X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC BRONCHIAL ASTHMA</u> DUE TO (c) <u>Allergy.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>45 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GRIEVANCE AND WORRY OVER Recent death of Wife</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN</u> , 19 <u>27</u> , to <u>Oct. 17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct. 13</u> , 19 <u>60</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Spiller</u>				ADDRESS (Street, city or town, state) <u>4506 R. I. Ave.</u>		DATE SIGNED <u>10-17-60</u>	
PHYSICIAN'S NAME (Type) <u>William W. Spiller</u>				<u>BRENTWOOD</u>		<u>Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-20-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson &amp; Jenkins</u>				ADDRESS <u>4804 Ha Ave</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 19 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Christina S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11501

CERTIFICATE OF DEATH

11501

<p>1. NAME OF DECEASED <i>JOHN J. SMITH</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>1910-10-15</i></p>	
<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>1935-05-10</i></p>	
<p>9. NAME OF SPOUSE <i>Mary E. Smith</i></p>		<p>10. DATE OF DEATH <i>1955-03-20</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MANNER OF DEATH <i>Natural</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>16. SIGNATURE OF WITNESS <i>John Doe</i></p>	

FILED - CIVIL CLERK

RECEIVED  
BALTIMORE  
MAY 20 1955

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

11690

11768

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>				c. LENGTH OF STAY IN 1b <u>1 DAY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF HOSPITAL ANDREWS</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ELI</u> Last <u>GORDON</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 Oct 60</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>3</u> Hours <u>37</u>		IF UNDER 24 HRS. Min. <u>37</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL E. GORDON</u>				14. MOTHER'S MAIDEN NAME <u>Theresa G. Forbes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>MOTHER</u> Address <u>SAME AS #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>774</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Respiratory Disease of the newborn</u> DUE TO (c) <u>Prematurity.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 mins.</u> <u>1 hr. 45 mins.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1928 to 1960</u> to <u>3145 16 Oct</u> , 19 <u>60</u> tho (I) (we) last saw the deceased alive on <u>16 Oct 1960</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Arnold A. Abramo</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>16 Oct 60</u>			
22c. PHYSICIAN'S NAME (Type) <u>ARNOLD A ABRAMO CAPT USAF MC</u>				22d. ADDRESS <u>USAF HOSPITAL ANDREWS ANDREWS AFB WASH DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. F. Taylor</u> ADDRESS <u>909 6TH ST, N.W. D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 19 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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ST 3-2630

**B. F. TAYLOR FUNERAL HOME INC.**

909 6TH ST. N.W.  
~~1702-04 12TH ST N.W.~~  
WASHINGTON, D.C.

SUPERVISOR OF  
DIVISION OF STATISTICAL  
RESEARCH & RECORDS.  
MARYLAND STATE DEPARTMENT  
OF HEALTH.



SIR:

ITEM 23B OF THIS CERTIFICATE IS NOT COMPLETE FOR REASONS FOLOWING REASONS.

- (1) THE FATHER OF THE BABY IS OVERSEAS (INCHON COREA) TELEGRAHM HAS BEEN SENT BY AIR FORCE REGISTRAS OFFICE.
- (2) MOTHER IS STILL CONFINED TO HOSPITAL (ANDREWS AIR FORCE BASE) IN HYSTERICAL CONDITION FOR THE PAST TWO DAYS.

FOR FURTHER INFORMATION CALL SGT.STRATTON. RE 5-8900-EXT 227.

YOURS TRULY,

*B. F. Taylor.*  
B.F.TAYLOR



$\frac{1}{\sqrt{\pi}} \int_{-\infty}^{\infty} f(x) e^{-x^2} dx = \frac{1}{\sqrt{\pi}} \int_{-\infty}^{\infty} f(x) e^{-x^2} dx$

11742

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George Co. MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Hgts Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7606 Kipling Pky</u>		d. STREET ADDRESS <u>7606 Kipling Pky</u>	
3. NAME OF DECEASED (Type or print) <u>MARTIN J GORRICK</u>		4. DATE OF DEATH <u>OCTOBER 7 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ellicott &amp; Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>LUKE GORRICK</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>7606 Kipling Pky</u>	
17. INFORMANT <u>Helen Cotts</u>		Address <u>7606 Kipling Pky</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterovascular Heart Disease</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterovascular CVA disease</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u> <u>15 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 11 1954</u> to <u>Oct 7 1960</u> that I last saw the deceased alive on <u>October 7 1960</u> and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6124 Central Ave</u> DATE SIGNED <u>10/7/60</u>			
ACTUAL SIGNATURE <u>William Brainin M.D.</u>		PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-10-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Christ Church</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber E.</u> ADDRESS <u>517-11th St S.E.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 11 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be released by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11769

CERTIFICATE OF DEATH

11692  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>		c. LENGTH OF STAY IN 1b <u>3 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie X</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nursing Home</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Solomon</u> Last <u>Grayson</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28 1875</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Grayson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Clobet</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>717-07-6854</u>		INFORMANT <u>Lawrence A. Grayson</u>		Address <u>Bowie, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434-1 Congestive Heart Failure</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Gen. Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia</u> <u>Prostatism</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>unknown</u> <u>unknown</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sgt</u> , 1959, to <u>Oct</u> , 1960 that I last saw the deceased alive on <u>Oct 10</u> , 1960, and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bowie, Ind</u> DATE SIGNED <u>10/11/60</u>							
ACTUAL SIGNATURE <u>Henry A. Wise Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>Henry A. Wise Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-15-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church of Ascension Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bowie Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman The Pure</u>				24a. REC'D BY REGISTRAR <u>1870-916</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	

WASH. DC

*[Faint, mostly illegible text, likely a death record or obituary. Some words are difficult to decipher but appear to include:]*

*... of ...*  
*... died ...*  
*... at the age of ...*  
*... was born ...*  
*... and ...*  
*... of ...*  
*... died ...*  
*... at the age of ...*  
*... was born ...*  
*... and ...*  
*... of ...*

*[Handwritten signature and date:]*  
*Wm. H. ...*  
*1900*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

11770  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11693

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c. LENGTH OF STAY IN 1b <b>51 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		d. STREET ADDRESS <b>101 WILSON ROAD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSP ANDREWS, WASH 25 DC</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MALCOM</b> Middle <b>CUMMINGS</b> Last <b>GROW</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>20</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 NOVEMBER 1887</b>
9. AGE (In years lost birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ARMY - USAF</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED USAF</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>ALVA S CUMMINGS</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH W WATSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>MRS WINIFRED GROW (WIFE)</b>		Address <b>SAME AS ITEM #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, lobar, right middle &amp; lower lobes</b> DUE TO (b) <b>Cerebrovascular thrombosis &amp; coma</b> DUE TO (c) <b>Arteriosclerosis generalized, severe, cerebral</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gastric ulcer malignant &amp; solitary nodule left upper lobe lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>1 week</b> <b>12 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sep.</b> 1955, to <b>20 Oct.</b> 1960, that (I) (we) last saw the deceased alive on <b>19 Oct.</b> 1960, and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Maxwell W Steel Jr</b>		22b. DATE SIGNED <b>20 Oct 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>MAXWELL W STEEL JR, LT COL USAF</b>		22d. ADDRESS <b>(MC) USAF HOSP ANDREWS, WASH 25 DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-24-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joe. Hawley's Sons Inc</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 24 '60</b>	
ADDRESS <b>1786 Pa Ave. N.E.</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton S. Hume</b>	



11603

11710

CERTIFICATE OF DEATH

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
11702					11695				
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Heights 1558-1				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 6004 Walhonding Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Mary Jewell Hamilton			4. DATE OF DEATH Month Day Year Oct. 24 19 60						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 Oct. 1885		9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk <del>XXXX</del>			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME James Dillehay				14. MOTHER'S MAIDEN NAME Martha Jewell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT George W. Jewell-son-Riverdale, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Acute pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerotic heart dis. (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 15, 1960 to Oct 24, 1960, that (I/we) last saw the deceased alive on Oct 24, 1960, and that death occurred at 11:45 from the causes and on the date stated above.									
22a. SIGNATURE William D. Rosson M.D.				22b. DATE 10/24/60		22c. PHYSICIAN'S NAME (Type) Dr. William Rosson M.D.			
22d. ADDRESS 5701 - 85th Ave. Hyattsville., Md				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/29/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				25a. REC'D BY REGISTRAR DATE OCT 27 '60		25b. REGISTRAR'S SIGNATURE Clifford S. Kline			

11303

CERTIFICATE OF DEATH

11303

John John

John John

John John

John John

John John

John John

John John

John John

11746

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>TEXAS</u> b. COUNTY <u>BOX-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. LENGTH OF STAY IN 1b <u>adm 7-1960</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELLEN B. HAKES</u>		4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 16-1890</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>0</u> Hours <u>0</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>CHARLES A. BUND</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN WITHERSPOON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Haemopneumothorax 519.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Malignancy?</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>20 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic heart disease 420.1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>7-19-</u> 19 <u>60</u> to <u>10-31-</u> 19 <u>60</u> that I last saw the deceased alive on <u>10-31-</u> 19 <u>60</u> , and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bridget P. Unknown</u>		ADDRESS (Street, city or town, state) <u>LAUREL SANITARIUM</u> DATE SIGNED <u>10-31-60</u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>		<u>LAUREL MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/4/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mission Burial Park</u>	22d. LOCATION (City, town, or county) <u>San Antonio, Texas</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>NOV 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11548

CERTIFICATE OF DEATH

11548



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reinterment.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11696

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>DC</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash DC</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>NOEL Irving HERPICH</u>		4. DATE OF DEATH <u>10-14-1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/34</u>
9. AGE (In years, last birthday) <u>26</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE I. Herpich</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANN (UNKNOWN)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES U.S. Navy</u>		16. SOCIAL SECURITY NO. <u>252-52-9716</u>	
17. INFORMANT <u>U.S. Navy Records</u>		Address <u>Nav. Apt</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL LACERATIONS +</u> 816X DUE TO <u>Contusions - FRACTURE Skull base</u> Conditions, if any, which gave rise to immediate cause (b) <u>LACERATIONS + Contusions</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident - M.V.</u>	
20c. TIME OF INJURY Month, Day, Year <u>10/14/1960</u> Hour <u>  </u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Pr. Geo. Md</u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-14-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/24/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL CEM</u>		22d. LOCATION (City, town, or county) <u>ARLINGTON</u> (State) <u>VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u> ADDRESS <u>1400 Chapin St NW Wash. DC</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>OCT 24 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 of 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11771

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11697

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X-3			
3. NAME OF DECEASED (Type or print) First Inez Middle Last Herring				4. DATE OF DEATH Month 10 Day 18 Year 19 60			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11/24/14	
9. AGE (In years lost birthday) yrs. 45		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) N.W. South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Herring				14. MOTHER'S MAIDEN NAME Minerva Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary hemorrhage 002X DUE TO Pulmonary tuberculosis, far advanced, active Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 30 min. 3 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/7/ 1960 to 10/18 1960, that (I) (we) last saw the deceased alive on 10/18 1960, and that death occurred at 1:05 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/18/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10/18/60		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hall Bros 621 Florida Ave N.W.				25a. REC'D BY REGISTRAR DATE OCT 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville Md.</b>			c. LENGTH OF STAY IN 1b <b>2 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5353 Pine St</b>				d. STREET ADDRESS <b>5353 Pine St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Evelyn</b> Middle <b>Corrine</b> Last <b>Hill</b>				4. DATE OF DEATH Month <b>October</b> Day <b>27</b> , Year <b>19 60</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 24, 1907</b>	
				9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Frank Zimmerman</b>				14. MOTHER'S MAIDEN NAME <b>Nellie ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elaine C. Morgan</b> Address <b>844 Spring Street Macen Georgia</b> <b>Daughter</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Penetrating Wound of Lungs</b> DUE TO <b>Heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gunshot wound</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>inst</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by a Shotgun at close range</b>					
20c. TIME OF INJURY Hour <b>a. m.</b> Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dayton O Watkins</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dayton O Watkins</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Transportation</b>		<b>Oct 29, 1960</b>		<b>Barnett</b>		<b>Georgia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 31 '60</b>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kenna</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

11704

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11699

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>13 Hr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 27</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>904 64th Ave. N.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>B</b>		Middle <b>Hill</b>		Last <b>Hill</b>	
4. DATE OF DEATH <b>Oct. 8</b>		Month <b>8</b>		Day <b>19</b>		Year <b>60</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. ? 1880 ?</b>	
9. AGE (In years last birthday) <b>80 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Michael Barber</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Hopewell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Florence Smith Great Mills md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA of CERVIX</b> DUE TO <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>WITH METASTASIS</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 8</b> 19 <b>60</b> , to <b>Oct. 8</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Oct. 8</b> 19 <b>60</b> , and that death occurred at <b>3:40 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm K. Jureco</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>10-14-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Face</b>		23d. LOCATION (City, town, or county) (State) <b>Great Mills, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. G. Mattingly</b>				25a. REC'D BY REGISTRAR <b>131-11th S.E.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kines</b>	
DATE <b>OCT 14 '60</b>							



11704

CERTIFICATE OF DEATH

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11773

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11700

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
c. LENGTH OF STAY IN 1b 2 months and 16 days		d. STREET ADDRESS 1710 Kenilworth Ave., N.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William A. Hinton		4. DATE OF DEATH Month 10/18/ Day Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/2/1897
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parking lot attendant		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Hinton		14. MOTHER'S MAIDEN NAME Malinda Jeffries	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Bronchogenic carcinoma, right main bronchus, with metastasis to adrenal glands DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Pulmonary hemorrhage; atelectasis, massive, right lung; arteriolar nephrosclerosis, kidney, moderate; coronary atherosclerosis, moderate			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/2/10.1860 to 10/18/1960, that (I) (we) last saw the deceased alive on 10/18/1960, and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 10/18/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10/19/60	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Washington, D. C.
24. FUNERAL DIRECTOR'S SIGNATURE H. S. Washington & Son 4925 Deane Ave NE		25a. REC'D BY REGISTRAR DATE OCT 21 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11700

STATE OF OHIO

11700

Benjamin Franklin, 1764-1790  
Benjamin Franklin, 1764-1790

Benjamin Franklin, 1764-1790  
Benjamin Franklin, 1764-1790

11700

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

11705

11701

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GEN. HOSP.</u>				d. STREET ADDRESS <u>136 9TH ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>HELEN</u>		First Middle Last <u>HIRSH</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 20, 1905</u>		9. AGE (In years last birthday) <u>5-2</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sewn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>knitting</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>KALMAN ROSENKRANTZ</u>				14. MOTHER'S MAIDEN NAME <u>ROSE HIRSCHKOWITZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis of Right Coronary with Myocardial Infarction</u> DUE TO (c) <u>Coronary Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>  <u>3 weeks</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 13</u> 19 <u>60</u> to <u>Oct 16</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Oct 16</u> 19 <u>60</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William Brainin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <u>10/16/60</u> SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>				22d. ADDRESS <u>6124 Central Ave, Capitol Hill Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-18-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MELWOOD CEM.</u>		23d. LOCATION (City, town or county) (State) <u>FARMINGDALE LONG ISLAND N.Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>GOLDBERG FUNERAL HOME</u>				ADDRESS <u>4217 9TH ST. NW, DC</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 18 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>			

MEDICAL CERTIFICATION

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REMARKS: THE DEATH OF THE  
CEREMONY OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

11706

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11702

Item 8 Film 6273 10-24-60 et

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Madeline</b>		4. DATE OF DEATH <b>Oct. 2 1960</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-18-83 1893</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Wash. D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Donohue,</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. M. A. Maschauer, -daughter,</b>		Address <b>3605 Bunker Hill Rd. Mt. Rainier, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>181.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral Hydroureter and Hydronephrosis</b> DUE TO (c) <b>Carcinoma of the Urinary Bladder</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> , 19 <b>Oct. 2</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Oct. 2</b> , 19 <b>60</b> , and that death occurred at <b>10:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>10/2/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. L. ETIENNE</b>		22d. ADDRESS <b>College Park, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-5-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>WASH. D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 10 '60</b>	
ADDRESS <b>3531 La Grange</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



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11774

## CERTIFICATE OF DEATH

11703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLINTON</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SOUTHERN MARYLAND MEDICAL CENTER</b>		d. STREET ADDRESS <b>6972 ALLENTOWN RD.</b>	
3. NAME OF DECEASED (Type or print) First <b>WATSON</b> Middle <b>MORACE</b> Last <b>INSCOE</b>		4. DATE OF DEATH Month <b>OCT.</b> Day <b>31</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 12 1913</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>7</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STATIONARY ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ST. ELIZABETH'S HOSP.</b>	
11. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>MORACE CONNLEY INSCOE</b>		14. MOTHER'S MAIDEN NAME <b>CAREY BELL JENKINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>1942-1944</b>	
17. INFORMANT <b>BROTHER</b> Address <b>6947 ALLENTOWN RD. CLINTON, MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>420.1</b> (b) <b>ACUTE MYOCARDIAL INFARCTION</b> (c) <b>HYPERTENSIVE-ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH <b>25 MINUTES</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <b>NONE</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>None</b> a.m. <b>None</b> p.m.		20d. INJURY OCCURRED While <b>None</b> at work <b>None</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) <b>None</b> (County) <b>None</b> (State) <b>None</b>	
21. I certify that I attended the deceased from <b>Sept. 1956</b> , to <b>Present</b> 19 <b>60</b> , that I last saw the deceased alive on <b>Oct. 1st</b> , 19 <b>60</b> , and that death occurred at <b>4:40</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur Shaver Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>Branch Ave., Clinton, Md.</b> DATE SIGNED <b>10/31/60</b>	
PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR. M.D. BRANCH AVE. - CLINTON, MD.</b>		DATE <b>NOV 3 60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-2-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Washington National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Clinton, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chamber G.</b> ADDRESS <b>517-11th St. S.E.</b>		24a. REC'D BY REGISTRAR <b>NOV 3 60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR ATS (4)  
ISM 9/59

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11707  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12995

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>R.F.D. 1304 Westphalia Road</b>	
3. NAME OF DECEASED (Type or print) <b>Jackson Baby Boy</b>		4. DATE OF DEATH <b>Oct. 28 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1960</b>
9. AGE (In years last birthday) <b>4 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Smith</b>	
14. MOTHER'S MAIDEN NAME <b>Charlotte L. Jackson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>762-55</b>		17. INFORMANT <b>Mother Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity (11/12 g)</b> DUE TO (b) <b>Pneumonia</b> DUE TO (c) <b>Asphyxia</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 28 1960</b> to <b>Oct. 28 1960</b> , that (I) (we) last saw the deceased alive on <b>Oct. 28 1960</b> and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas A. Christensen</b>		22b. DATE SIGNED <b>10/30/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas A. Christensen, M.D.</b>		22d. ADDRESS <b>6905 Baltimore Ave. College Park, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>11-9-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Maryland</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>		25a. REC'D BY REGISTRAR <b>NOV 14 60</b>	
25b. REGISTRAR'S SIGNATURE <b>C. H. S. H. H.</b>		25c. REGISTRAR'S NAME	

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11707

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11704

11775

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville Md		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6303 Balfour Drive		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 West Hyattsville Md.	
4. DATE OF DEATH Month Day Year Oct 29, 1960 19		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Marie Last Jensen		4. DATE OF DEATH Month Day Year Oct 29, 1960 19	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 2, 1861	
9. AGE (In years last birthday) 99 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Denmark		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ? Skow		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT John M Jensen		790 Kreeger Drive Adelphi Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Pulmonary Edema DUE TO (b) Arterio sclerotic Heart disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Two weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dayton O Watkins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dayton O Watkins		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10-30-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 1, 1960	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE NOV 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Pinner	





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11705

11708

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo General</u>				d. STREET ADDRESS <u>RT 156</u>			
3. NAME OF DECEASED (Type or print) <u>ELVIN COATES JOHNSON</u>				4. DATE OF DEATH <u>Oct 27</u> 19 <u>60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-11-31</u>	9. AGE (In years less birth day) <u>29</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>Excavating</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Claben C Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Galloway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>usany</u>		17. INFORMANT <u>Louise Shaffer, as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution - High voltage inst</u> <u>914.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO _____ (d) _____ (e) _____ stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>High tension wire fell on subject</u>					
20c. TIME OF INJURY Hour <u>1030</u> o. m. p. m.	Month, Day, Year <u>1960</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Excavation</u>	20f. (City or town) <u>Andrews</u>	County <u>Prince Geo</u>		State <u>md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) <u>Waterbury</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>				ADDRESS <u>Arner</u>		24a. REC'D BY REGISTRAR <u>Oct 31 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>William Reese</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

11702

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, illegible]		SEX [Faint text, illegible]	
AGE [Faint text, illegible]		RACE [Faint text, illegible]	
DATE OF DEATH [Faint text, illegible]		TIME OF DEATH [Faint text, illegible]	
PLACE OF DEATH [Faint text, illegible]		CITY [Faint text, illegible]	
COUNTY [Faint text, illegible]		STATE [Faint text, illegible]	
CAUSE OF DEATH [Faint text, illegible]			
MANNER OF DEATH [Faint text, illegible]			
SIGNATURE OF MEDICAL EXAMINER [Faint text, illegible]			
DATE [Faint text, illegible]			
SIGNATURE OF WITNESS [Faint text, illegible]			
DATE [Faint text, illegible]			

1

10-20-10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 11706										
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Upper Marlboro					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital					d. STREET ADDRESS Rt 2 Box 1518			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Major Delano Johnson, Jr.					4. DATE OF DEATH Month Day Year Oct. 29, 1960 19					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1960		9. AGE (In years last birthday) yrs. Months Days Hours Min. 5 5		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Major Delano Johnson, Sr.					14. MOTHER'S MAIDEN NAME Ruth Marie Pinkney					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Ruth Marie Pinkney, Same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Lobar 1 week DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Dayton Watkins					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) Dayton O. Watkins					DATE SIGNED					
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11-1-60		22c. NAME OF CEMETERY OR CREMATORY Forest Hills			22d. LOCATION (City, town, or county) (State) Clinton Md			
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington					ADDRESS 4925 Reame Ave NE DC		24a. REC'D BY REGISTRAR DATE NOV 2 '60		24b. REGISTRAR'S SIGNATURE C. S. P. Grant	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
11710									
Item 9 Film 274 11-1-60 10-20-60 et									
11707									
1. PLACE OF DEATH o. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> <b>prince George</b> COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>13 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>60 Hyattsville</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>5805 Queens Road, Chaple Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Annie</b>		First		Middle		Last <b>Kearns</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>11</b> Year <b>19 60</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-17-78</b>		9. AGE (In years lost birthday) yrs. <b>82 1/2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED U.S. GOV'T.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PATRICK MORKIN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Mrs. Agnes Smith</b>		Address <b>Hyatts. Md. 3431 Stanford St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetis Mellites</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fractured right Hip</b> DUE TO (c) <b>—</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at nursing home</b>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>— — 19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) <b>Pr. Geo.</b>		(County) (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 27</b> , 19 <b>60</b> , to <b>Oct. 11</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Oct. 10</b> , 19 <b>60</b> , and that death occurred at <b>2:20 A.M.</b> the causes and on the date stated above.									
22a. SIGNATURE <b>Sanford H. Eisenberg</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. ADDRESS <b>6512 Western Ave, Chevy Chase 15, Md</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Sanford Eisenberg, M.D.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10-14-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) <b>Washington</b>		(State) <b>D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>				ADDRESS <b>3821 14th St. N.W.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



2011

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55-71-



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11776

CERTIFICATE OF DEATH

11708

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges'</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>#7 Summer Road</b>		d. STREET ADDRESS <b>#7 Summer Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Augusta</b> Middle <b>L.</b> Last <b>Kidwell</b>		4. DATE OF DEATH Month <b>October</b> Day <b>17</b> Year <b>1960.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1872</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Boswell</b>		14. MOTHER'S MAIDEN NAME <b>Louise Venable</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>Augustine L. Kidwell</b>		Address <b>#7 Summer Road., Washington 23, D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Arteriosclerosis (Senile)</b> DUE TO (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>natural Causes</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 7</b> , 19 <b>55</b> , to <b>Oct 17</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Oct 17</b> , 19 <b>60</b> , and that death occurred at <b>4:30 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Paul C. VanNatta</b> M.D.		5440 Silver Hill Road, Parkland, Maryland.	
PHYSICIAN'S NAME (Type) <b>Paul C. VanNatta, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/21/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home—Upper Marlboro, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 2 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11711

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11709

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2821 - 63rd PLACE</b>				d. STREET ADDRESS <b>1 2821 - 63rd PLACE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>KNEESSI</b> Last <b>MELVA</b> <del>(Type)</del>				4. DATE OF DEATH Month <b>OCTOBER 31</b> Day <b>19</b> Year <b>60</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/5/19</b>	
9. AGE (In years lost birthday) <b>41</b> yrs.		10. IF UNDER 1 YEAR Months <b>41</b> Days <b>41</b> Hours <b>41</b> Min.		11. IF UNDER 24 HRS. Months <b>41</b> Days <b>41</b> Hours <b>41</b> Min.		12. IF UNDER 1 YEAR Months <b>41</b> Days <b>41</b> Hours <b>41</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Icer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baking Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN A. KNEESSI</b>				14. MOTHER'S MAIDEN NAME <b>IRENE KINES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-30-4588</b>		17. INFORMANT <b>LESTER J. FLETCHER, 2821 - 63rd PL., CHEVERLY, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>epileptic convulsion</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>2 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 2</b> 19 <b>60</b> , to <b>Oct 31</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Oct 31</b> 19 <b>60</b> , and that death occurred at <b>9:30</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Leon R. Levitsky</b>				22b. DATE <b>11/1/60</b>		22c. PHYSICIAN'S NAME (Type) <b>LEON R. LEVITSKY</b>	
22d. ADDRESS <b>3408 RHODE ISLAND AVE., MT. RAINIER, MD.</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE <b>11/1/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/3/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, Inc.</b> <b>Raymond A. Ziska</b>				25a. REC'D BY REGISTRAR <b>NOV 4 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

11760

CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Date of death: \_\_\_\_\_

6. Place of death: \_\_\_\_\_

7. Cause of death: \_\_\_\_\_

8. Signature of physician: \_\_\_\_\_

9. Signature of registrar: \_\_\_\_\_

10. Date of registration: \_\_\_\_\_

11777

CERTIFICATE OF DEATH

11710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>(DISTRICT OF COLUMBIA)</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON (RURAL)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSP ANDREWS, WASH 25 DC</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>MAE</b> Last <b>KOOGLE</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>19</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 APRIL 1884</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>HOME WORK</b>	
10. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		11. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
12. FATHER'S NAME <b>William Martin McGrew</b>		13. MOTHER'S MAIDEN NAME <b>Mary Susan Harris</b>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		15. SOCIAL SECURITY NO. <b>226-28-8131</b>	
16. INFORMANT <b>MRS DOROTHEA M EDDINS</b>		Address <b>6349 BRANCH AVE SE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO <b>450.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive heart failure, diabetes,</b> (c) <b>generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>15 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1 Sept 1960</b> , to <b>19 Oct 1960</b> , that I last saw the deceased alive on <b>19 Oct 1960</b> , and that death occurred at <b>1430 M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward G Dowds</b>		DATE SIGNED <b>19 Oct '60</b>	
PHYSICIAN'S NAME (Type) <b>EDWARD G DOWDS, CAPT USAF MC</b>		ADDRESS (Street, city or town, state) <b>ANDREWS AIR FORCE BASE, WASHINGTON 25, DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 22, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Gmtery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24. REC'D BY REGISTRAR DATE <b>OCT 24 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneale</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 11711									
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			56	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8112 New Hampshire Ave.</b>					d. STREET ADDRESS <b>8112 New Hampshire Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mozelle</b> Middle <b>M</b> Last <b>Kunowsky</b>					4. DATE OF DEATH Month <b>Oct.</b> Day <b>28</b> Year <b>1960</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/27/97</b>		9. AGE (In years last birthday) <b>63</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during life even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Eugene J. Martin</b>					14. MOTHER'S MAIDEN NAME <b>Gertrude G. Gains</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Margarrette K. Edwards</b> Address <b>8112 N. H. Ave.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Adema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular renal disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Dayton O Watkins</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>DAYTON O WATKINS</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL CREMATION, (Specify) <b>Burial</b>			22b. DATE THEREOF <b>11/1/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington Va.</b>			22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home</b> ADDRESS <b>4812 Ga. Ave. N.W. D.C.</b>					24a. REC'D BY REGISTRAR DATE <b>NOV 3 1960</b>		24b. REGISTRAR'S SIGNATURE		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

11712

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 46		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. Gen. Hosp.				d. STREET ADDRESS 3333 Buchanan St.			
3. NAME OF DECEASED (Type or print) First Middle Last DONALD JOSEPH KURZ				4. DATE OF DEATH Month Day Year Oct. 7 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 Sept. 1926	
9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Trade		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph A. Kurz				14. MOTHER'S MAIDEN NAME M. Fay Rude			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11		17. INFORMANT Margaret G. Kurz (Wife) Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral laceration & contusions 802X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compound Fracture Skull DUE TO (c) Fracture neck PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Train Collided with Car					
20c. TIME OF INJURY Month, Day, Year Hour a. m. - Oct 7 1960 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) RR Crossing		20f. (City or town) (County) (State) Beltville Pr Geo Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dayton Watkins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dayton O. Watkins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11 Oct 60		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Ceme.		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE OCT 13 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Time of Death	
John Doe		45		Male		White		10/15/1917		10:30 AM	
Residence		Occupation		Cause of Death		Manner of Death		Place of Death		Signature of Examiner	
123 Main St, Boston		Carpenter		Heart Disease		Natural		Home		[Signature]	
Physician		Medical Examiner		Coroner		Burial		Interment		Remarks	
Dr. Smith		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Time of Report		Place of Report		Signature of Physician		Signature of Medical Examiner		Signature of Coroner	
10/16/1917		11:00 AM		Boston		[Signature]		[Signature]		[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11713

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11713

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>P. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>				c. LENGTH OF STAY IN 1b <b>11 da. 7 hr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George Co. Hosp</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>P.</b> Last <b>Lambros</b>				4. DATE OF DEATH Month <b>October</b> Day <b>13</b> Year <b>19 60</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 24, 1893</b>	
9. AGE (In years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>7</b>		11. IF UNDER 24 HRS. Hours <b>7</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Restaurant Business</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Business</b>			
11. BIRTHPLACE (State or foreign country) <b>Greece</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Peter Lambros</b>				14. MOTHER'S MAIDEN NAME <b>Theodora Kolofiras</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>579-10-6751A</b>			
17. INFORMANT <b>5401 Taylor Road</b> <b>Athena Lambros Riverdale, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> DUE TO <b>465X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Disease</b> DUE TO <b>Pulmonary Infarct</b> (c) <b>Pulmonary Infarct</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>10-2</b> <b>1960</b> , to <b>10-13</b> <b>1960</b> that (I) (we) last saw the deceased alive on <b>10-13</b> <b>1960</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Aaron Deitz</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <b>Aaron Deitz, M. D.</b>							
22d. ADDRESS <b>4314 Gallatin St. Hyatts., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
23b. DATE THEREOF <b>10/17/60</b>							
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>							
23d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. Washington, D. C.</b>							
25a. REC'D BY REGISTRAR <b>DATE OCT 17 1960</b>							
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							



11113

CERTIFICATE OF DEATH

11113

James M. ...

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

11714

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Prince George</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			
c. LENGTH OF STAY IN 1b <b>1 1/2 Days</b>				d. STREET ADDRESS <b>3108 Parkway</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Stanley Seth Lander</b>				4. DATE OF DEATH <b>Oct. 5 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-24-20</b>	
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Q.M. Corp. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas P. Lander</b>				14. MOTHER'S MAIDEN NAME <b>Williemine Forsyth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give title and dates of service) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>320184310</b>		17. INFORMANT <b>Marcia G. Lander (Wife) Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulm. edema</b>							
522X DUE TO <b>acute pulm. edema</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>acute pulm. edema</b>							
(c) <b>Corrected by surgery</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 3 1960</b> to <b>Oct. 5 1960</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>7:05 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William B. Hagen</b> M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>William B. Hagen</b>	
22d. ADDRESS <b>College Park, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/7/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Ceme.</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>DATE OCT 10 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hagen</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be filed with the funeral director, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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REPLY AND DEPARTMENT OF HEALTH  
FEDERAL BUREAU OF INVESTIGATION  
UNITED STATES DEPARTMENT OF JUSTICE

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CERTIFICATE OF DEATH

11715

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PR GEO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>same</u> b. COUNTY <u>same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>		c. LENGTH OF STAY IN 1b <u>14 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7009 - WAKE Forest Dr</u>		d. STREET ADDRESS <u>same</u>	
3. NAME OF DECEASED (Type or print) <u>PETERIS P. LEJINS</u>		4. DATE OF DEATH <u>Oct 28 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 10, 1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ORIG PROF</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	
11. BIRTHPLACE (State or foreign country) <u>LATVIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>LATVIA.</u>	
13. FATHER'S NAME <u>Peteris Lejins</u>		14. MOTHER'S MAIDEN NAME <u>Maiga Jagars</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Peter P. Lejins</u>		Address <u>7009 Wake</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 422 <u>due to</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>Arterio-sclerotic cardiovascular disease</u> DUE TO (b) <u>desire</u> DUE TO (c) <u>desire</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic Hypertrophy</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Dec 1957</u> to <u>Oct 1960</u> , that I last saw the deceased alive on <u>Oct 28 1960</u> , and that death occurred at <u>10:50 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Etienne</u>		ADDRESS (Street, city or town, state) <u>4713 - BERWYN Rd</u>	
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>		DATE SIGNED <u>10/29/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 31, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers &amp; Co. Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Nov 3 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kruza</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of undertaker		12. Signature of witness	
13. Signature of funeral home		14. Signature of cemetery		15. Signature of burial place	
16. Signature of interment place		17. Signature of burial place		18. Signature of burial place	
19. Signature of burial place		20. Signature of burial place		21. Signature of burial place	
22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
25. Signature of burial place		26. Signature of burial place		27. Signature of burial place	
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49. Signature of burial place		50. Signature of burial place		51. Signature of burial place	
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58. Signature of burial place		59. Signature of burial place		60. Signature of burial place	
61. Signature of burial place		62. Signature of burial place		63. Signature of burial place	
64. Signature of burial place		65. Signature of burial place		66. Signature of burial place	
67. Signature of burial place		68. Signature of burial place		69. Signature of burial place	
70. Signature of burial place		71. Signature of burial place		72. Signature of burial place	
73. Signature of burial place		74. Signature of burial place		75. Signature of burial place	
76. Signature of burial place		77. Signature of burial place		78. Signature of burial place	
79. Signature of burial place		80. Signature of burial place		81. Signature of burial place	
82. Signature of burial place		83. Signature of burial place		84. Signature of burial place	
85. Signature of burial place		86. Signature of burial place		87. Signature of burial place	
88. Signature of burial place		89. Signature of burial place		90. Signature of burial place	
91. Signature of burial place		92. Signature of burial place		93. Signature of burial place	
94. Signature of burial place		95. Signature of burial place		96. Signature of burial place	
97. Signature of burial place		98. Signature of burial place		99. Signature of burial place	
100. Signature of burial place		101. Signature of burial place		102. Signature of burial place	

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Item 2b Film 275 10-24-60 et

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince Georges Co.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN 1b <b>7 Mo.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>P. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkland</b> d. STREET ADDRESS <b>5505 Parkland Ct. #301</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Edward</b> Last <b>Lennon</b>		4. DATE OF DEATH Month <b>10/15/60</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>wh</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/9/92</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>15</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Wash., D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Lennon</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Callaher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>son—John E. Lennon—6851 Farragut st. Hyattsville</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>420.0</b> DUE TO <b>Coronary Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic Heart Disease</b> DUE TO <b>Pneumonia secondary to Bronchial</b> (c) <b>Pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>3 mo.</b> <b>6 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 7 1960</b> to <b>Oct 15 1960</b> that (I) (we) last saw the deceased alive on <b>Oct 14 1960</b> and that death occurred at <b>8:55</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>L W Malin</b>		22b. DATE SIGNED <b>10-16-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>L W M 2117 M.D.</b>		22d. ADDRESS <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1019-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City, town, or county) <b>Suitland, Md.</b> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home. - Washington D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 18 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			



11578

CERTIFICATE OF DEATH

11578



MAINTAIN THE DEPARTMENT OF HEALTH  
IN THE CITY OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CITY OF NEW YORK  
OFFICE OF THE REGISTRAR  
100 NASSAU ST. NEW YORK 100  
JANUARY 1900  
DEATH OF  
NAME  
AGE  
SEX  
RACE  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
SIGNATURE OF REGISTRAR  
OFFICE OF THE REGISTRAR  
100 NASSAU ST. NEW YORK 100

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11715

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11717

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>58 West Hyattsville</b>	
c. LENGTH OF STAY IN 1b <b>2 Days</b>		d. STREET ADDRESS <b>1 6600 23 Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Kayann Grace Anna Leon</b>		4. DATE OF DEATH Month Day Year <b>Oct. 4 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-15-60</b>
9. AGE (In years lost birthday) <b>3 1/2</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Pr. Geo. Co., Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Donald E</b>	
14. MOTHER'S MAIDEN NAME <b>Noreen Hueston</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Donald E. (same as #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrolyte Imbalance</b> <b>773.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Dehydration</b> DUE TO (c) <b>---</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no injury</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 2 19 60</b> to <b>Oct. 4 19 60</b> , that (I) (we) lost saw the deceased alive on <b>Oct. 4 19 60</b> , and that death occurred at <b>1:20 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Milos Jansa M.D.</b>		22b. ADDRESS <b>7401 Varnum St. Landover Hills, Md.</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct 6, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. France</b>		25a. REC'D BY REGISTRAR <b>OCT 6 '60</b>	
ADDRESS <b>254 Carroll St. N.W. - D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. France</b>	

1341

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G273 10-18-60 et

CERTIFICATE OF DEATH

11778

11718

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>PR. GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON, MD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>084 So. Md. Hosp. Center</u>		d. STREET ADDRESS <u>Box 367, Rt 1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH JANE LETCHER</u>		4. DATE OF DEATH Month Day Year <u>10 - 9 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1917</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>OHIO</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD ROBERTS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH WINKLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u> INFORMANT Address <u>ALEXANDER L. LETCHER - BRANDYWINE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO _____ (c) DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH <u>7</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <u>10-9</u> , 19 <u>60</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vivian Chang</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>So. Md. Hosp. Center</u>	
PHYSICIAN'S NAME (Type) <u>VIVIAN CHANG</u>		<u>CLINTON, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 13 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>Waldorf Md</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

11734

CERTIFICATE OF DEATH

11734

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11779

## CERTIFICATE OF DEATH

11719

See: Birth Cert. et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PR. GEO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> 47X.3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FERRINA NURSING HOME.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KAREN SUE LITTS</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT ALLEN Litts</u>		14. MOTHER'S MAIDEN NAME <u>BEVERLY Pauline Warren</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>parents</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYDROCEPHALOS, INTERNAL</u> DUE TO <u>750X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ANENCEPHALUS</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>LIFE</u> <u>LIFE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/11</u> , 19 <u>60</u> , to <u>10/12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10/11</u> , 19 <u>60</u> , and that death occurred at <u>3:30 p.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph J. McDONALD</u>		DATE SIGNED <u>JOSEPH J. McDONALD, M.D.</u> <u>7309 RIGGS ROAD</u> <u>UNIVERSITY CITY APTS.</u> <u>HYATTSVILLE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CO.</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>		ADDRESS <u>RIVERDALE, Md</u>	
24a. REC'D BY REGISTRAR <u>1960</u>		24b. REGISTRAR'S SIGNATURE <u>JOSEPH J. McDONALD, M.D.</u> <u>7309 RIGGS ROAD</u> <u>UNIVERSITY CITY APTS.</u> <u>HYATTSVILLE, MD.</u>	



CERTIFICATE OF DEATH

3011 BOND

Name of Deceased		John Doe	
Age		45	
Sex		Male	
Race		White	
Date of Death		10/15/1918	
Place of Death		Home	
Cause of Death		Pneumonia	
Signature of Physician		<i>[Signature]</i>	
Signature of Registrar		<i>[Signature]</i>	
Date of Registration		10/16/1918	
Place of Registration		Baltimore	
Signature of Coroner		<i>[Signature]</i>	
Signature of Burial Officer		<i>[Signature]</i>	
Date of Burial		10/17/1918	
Place of Burial		Catholic Cemetery	
Signature of Minister		<i>[Signature]</i>	
Signature of Undertaker		<i>[Signature]</i>	
Date of Issuance		10/16/1918	
Place of Issuance		Baltimore	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11720

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rivendale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>				d. STREET ADDRESS <u>2529 14<sup>th</sup> St - N.E.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruth Curania Lizas</u>				4. DATE OF DEATH Month Day Year <u>Oct. 21 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-8-60</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>13</u>		IF UNDER 24 HRS. Min. <u>13</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Theodore Lizas</u>				14. MOTHER'S MAIDEN NAME <u>Anita Lloyd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Hosp. Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>Prematurity</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>9-8-60</u> to <u>10-21-60</u> , that (I) (we) last saw the deceased alive on <u>10-21-60</u> , and that death occurred at <u>1:30</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>R.R. Gardie</u>				22b. DATE SIGNED <u>10-21-60</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/22/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		23d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 25 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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CERTIFICATE OF DEATH

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*[Faint, mostly illegible text from the reverse side of the document, appearing as bleed-through. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Date" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince e George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1 Hr</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ida</b>				4. DATE OF DEATH <b>Oct. 5 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 4, 1885</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>			
11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles Weeks</b>				14. MOTHER'S MAIDEN NAME <b>Payne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Yes</b>			
17. INFORMANT <b>Walter H. Long</b>				Address <b>7716 - Greeley Rd. Kentland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anasarca</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Hypertensive Coronary Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Unknown</b> years years.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 5</b> 19 <b>60</b> to <b>Oct. 5</b> 19 <b>60</b> that (I) (we) lost saw the deceased alive on <b>Oct. 5</b> 19 <b>60</b> and that death occurred at <b>2:45 PM</b> the causes and on the date stated above.							
22a. SIGNATURE <b>R. D. Baker MD</b>				22b. DATE SIGNED <b>10-5-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>R. D. BAKER, MD</b>				22d. ADDRESS <b>Prince Geo. Gen. Hospital, Cheverly, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>10-8-60</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Switland, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers &amp; Co. 517-11th St. S.E.</b>				25a. REC'D BY REGISTRAR <b>DATE OCT 11 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles S. Frank</b>							

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11717

11722

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Pr Geo</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheney</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo Hotel</u>				d. STREET ADDRESS <u>1838 Mass ave SE</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>PARK EARLY LOY</u>				<b>4. DATE OF DEATH</b> Month <u>10</u> - Day <u>9</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 20 1885</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Strutcar</u>		11. BIRTHPLACE (State or foreign country) <u>VA</u>			
13. FATHER'S NAME <u>RICHARD F LOY</u>				14. MOTHER'S MAIDEN NAME <u>Lidia A BEST</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-10-5665</u>		17. INFORMANT <u>Marguerite Bodin</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>arteriosclerotic Heart Disease</u> (c) <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
20f. (City or town) <u>  </u>		(County) <u>  </u>		(State) <u>  </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>10-10-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-13-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem.</u>			
22d. LOCATION (City, town, or county) <u>Blacksburg, Md.</u>		(State) <u>  </u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers &amp; Inc.</u>				ADDRESS <u>517-11th St. S.E.</u>			
24a. REC'D BY REGISTRAR <u>OCT 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MASSACHUSETTS DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <u>JOHN J. BROWN</u>		2. SEX <u>MALE</u>	
3. AGE <u>45</u>		4. DATE OF BIRTH <u>1910</u>	
5. PLACE OF BIRTH <u>NEW YORK</u>		6. OCCUPATION <u>LABORER</u>	
7. MARITAL STATUS <u>MARRIED</u>		8. PLACE OF DEATH <u>HOME</u>	
9. CAUSE OF DEATH <u>HEART DISEASE</u>		10. MANNER OF DEATH <u>NATURAL</u>	
11. SIGNATURE OF MEDICAL EXAMINER <u>[Signature]</u>		12. DATE OF EXAMINATION <u>1955</u>	
13. SIGNATURE OF REGISTRAR <u>[Signature]</u>		14. DATE OF REGISTRATION <u>1955</u>	

COMMONWEALTH OF MASSACHUSETTS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
11675

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11723

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College PK. MD.</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5011 Indian Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>A</u> Last <u>Luxen</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19 1900</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Allan Castle</u>		14. MOTHER'S MAIDEN NAME <u>Anna Groverman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mrs. Frances Wilson - dght - SAME</u>	
17. INFORMANT Address <u>Mrs. Frances Wilson - dght - SAME</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> 42021 DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Fibrosis &amp; Emphysema Chronic Obstructive Bronchitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>55</u> to <u>Sept 30</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Sept 29</u> 19 <u>60</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard L. Whelton</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Richard L. Whelton</u>		22d. ADDRESS <u>1021 University Blvd E Silver Spring Md</u>	
23a. BURIAL, CREMATION, or other final disposition <u>burial</u>		23b. DATE THEREOF <u>10/4/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th. St. N.W. Wash,</u>		25a. REC'D BY REGISTRAR <u>DOCT 3 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>		25c. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

11075



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. STREET ADDRESS <b>1907 Saratoga Drive</b>			
3. NAME OF DECEASED (Type or print) <b>MIDDLE First James</b> <b>FIRST Middle Nicholas</b> <b>Last MALLIS</b>				4. DATE OF DEATH <b>October 24 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 16, 1913</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Recovery of Supplies</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Giant Food Stores</b>			
11. BIRTHPLACE (State or foreign country) <b>New Castle, Delaware</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Mallis</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>4-14-50-11-3-53</b>				16. SOCIAL SECURITY NO. <b>218-34-547</b>			
17. INFORMANT <b>Mrs. Rose L. Mallis</b> Address <b>same as #2</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>30 mins</b> <b>2YRS +</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>FEB</b> 1957, to <b>OCT</b> 1960, that I last saw the deceased alive on <b>10/12</b> 19 <b>60</b> , and that death occurred at <b>8:05 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3501 HAMILTON ST</b> DATE SIGNED <b>10/24</b> ACTUAL SIGNATURE <b>Frank M. Trozzo Jr</b> M.D. PHYSICIAN'S NAME (Type) <b>FRANK M. TROZZO JR</b> <b>HYATTSVILLE, MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Oct 28, 1960</b>		<b>Arlington National Cem</b>		<b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers &amp; Co. Riverdale, Md.</b> ADDRESS <b>DATE OCT 26 '60</b>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11682  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11725

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>144th St. S.W.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Correll Manor 4922 LaSalle Rd.</u>		d. STREET ADDRESS <u>4228 18th St. N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>F.</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-1892</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes U.S.A</u>	
13. FATHER'S NAME <u>John J. Horley</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Pender</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Dr. M. Bernadette</u>		Address <u>4922 LaSalle Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>@ Hypertensive Cardio-Vascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 48</u> to <u>Oct 5</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Oct 3</u> , 19 <u>60</u> , and that death occurred at <u>8:32</u> P.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>William T. Saccardi</u> M.D.		22b. DATE SIGNED <u>10/5/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM T. SACCARDI</u>		22d. ADDRESS <u>1150 Conn. Ave. WASH. 6 DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-8-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>WASH. D. C.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 7 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>			



11882

CERTIFICATE OF DEATH

11882

75

Blank form with faint horizontal lines and a vertical margin line on the right. The form is divided into sections by horizontal lines, with some text visible in the top section, including "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Place of Death", "Cause of Death", "Signature", and "Registrar".



11756

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11757

HAWAIIAN STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS



1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]	
9. SIGNATURE OF MEDICAL EXAMINER [Faint text]		10. SIGNATURE OF WITNESS [Faint text]	
11. DATE OF EXAMINATION [Faint text]		12. PLACE OF EXAMINATION [Faint text]	
13. SIGNATURE OF REGISTRAR [Faint text]		14. SIGNATURE OF CLERK [Faint text]	
15. SIGNATURE OF NOTARY [Faint text]		16. SIGNATURE OF JURY [Faint text]	
17. SIGNATURE OF JURY [Faint text]		18. SIGNATURE OF JURY [Faint text]	
19. SIGNATURE OF JURY [Faint text]		20. SIGNATURE OF JURY [Faint text]	
21. SIGNATURE OF JURY [Faint text]		22. SIGNATURE OF JURY [Faint text]	
23. SIGNATURE OF JURY [Faint text]		24. SIGNATURE OF JURY [Faint text]	
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93. SIGNATURE OF JURY [Faint text]		94. SIGNATURE OF JURY [Faint text]	
95. SIGNATURE OF JURY [Faint text]		96. SIGNATURE OF JURY [Faint text]	
97. SIGNATURE OF JURY [Faint text]		98. SIGNATURE OF JURY [Faint text]	
99. SIGNATURE OF JURY [Faint text]		100. SIGNATURE OF JURY [Faint text]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11687

CERTIFICATE OF DEATH

11727

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier 47</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3401-Eastern Ave.</u>		d. STREET ADDRESS <u>3401-Eastern Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Olive</u> First <u>R.</u> Middle <u>Miller</u> Last		4. DATE OF DEATH <u>Oct. 5<sup>th</sup></u> 19 <u>60</u> Month <u>Oct.</u> Day <u>5<sup>th</sup></u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/16, 1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR <u>  </u> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Charles County Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Went</u>		14. MOTHER'S MAIDEN NAME <u>Hancock Ann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Coronary Artery Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-15 min.</u> <u>6-8 weeks</u> <u>3-4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 1, 1960</u> to <u>October 4, 1960</u> , that I last saw the deceased alive on <u>October 3, 1960</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Irey</u>		ADDRESS (Street, city or town, state) <u>7105 Riggs Rd. Hyattsville Md.</u> DATE SIGNED <u>Oct 4 1960</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/6/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kalder Funeral Home Inc.</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>OCT 7 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

(M)

(I)

11887

CERTIFICATE OF DEATH

11887

*[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

11683

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11728

1. PLACE OF DEATH a. COUNTY Prince Geo. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 3409-Toledo Terrace b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Pr. Geo. Hospital		d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GAY W. MOORE		4. DATE OF DEATH Month Day Year 10- 31 19 60	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1906
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. Labeling		10b. KIND OF BUSINESS OR INDUSTRY Library of Cong. N.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred B. Williams		14. MOTHER'S MAIDEN NAME Minnie L. Arnold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address Winter K. Moore-Husband-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute Myocardial Infarction DUE TO (b) Coronary Thrombosis DUE TO (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH immediate immediate approx 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/31 1960 to 10/31 1960 that (I) (we) last saw the deceased alive on 10/21 1960 and that death occurred at 7:00 AM, from the causes and on the date stated above.			
22a. SIGNATURE Lindall Gay		22b. DATE SIGNED 10/31/60	
22c. PHYSICIAN'S NAME (Type) Lindall Gay		22d. ADDRESS 403- East Capitol St. Wash, D.C.	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE THEREOF Nov. 3-60	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J.Wm. Lees Sons Co 300-4th St. N.E.		25a. REC'D BY REGISTRAR DATE NOV 3 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			



11158

CERTIFICATE OF DEATH

11483

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <u>Pr. Geo.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount Heights</u> <u>30</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pr. Geo. Gen. Hosp.</u>					d. STREET ADDRESS <u>606 62nd. Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ELLEN</u> Middle <u>MURPHY</u> Last					4. DATE OF DEATH Month <u>Oct</u> Day <u>18</u> Year <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 April 1900</u>		9. AGE (in years last birthday) <u>60</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nat. Cath. School</u>		11. BIRTHPLACE (State or foreign country) <u>N.J.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>? Mason</u>					14. MOTHER'S MAIDEN NAME <u>Unk.</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT <u>Thomas E. Murphy</u>			Address <u>Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>inst</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart failure</u> <u>2 years</u> DUE TO <u>Arterio Sclerotic Heart disease</u> (c) <u>allergic asthma</u> <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>allergic asthma</u> <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>										
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>no</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour <u>5:00</u> p. m. Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Dayton O. Watkins</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>DAYTON O. WATKINS</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nat Harmony Pk</u>		22d. LOCATION (City, town, or county) (State) <u>Shurff Rd Ept Md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington + Son</u>					ADDRESS <u>4925 Dean Ave</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

DATE SIGNED  
10-18-60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

11720

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11730

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General</b>				d. STREET ADDRESS <b>9011 Burnside Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>FRANCES</b> Last <b>Myers</b>				4. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-24-82</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Jones</b>				14. MOTHER'S MARDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Maurin O. Myers</b>		Address <b>4919 Bryston Dr. Annapolis Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Tamponade</b> <b>420.1</b> DUE TO <b>Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>October 8, 1960</b> , to <b>October 11, 1960</b> , that (I) (we) last saw the deceased alive on <b>October 11, 1960</b> , and that death occurred <b>6:55 p.m.</b> the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Chas. David Connors, M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/11/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Chas. David Connors, M.D.</b>				22d. ADDRESS <b>4410 74th Ave. Landover Hills Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-14-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Shilford, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co.</b>				ADDRESS <b>517-11th St. S.E.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 14 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneib</b>			

11730

CERTIFICATE OF DEATH

11730

Notary Public

Notary Public

Witness

Witness

Witness

FRANCIS

X

Notary Public

1

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 508 Haynes Road		d. STREET ADDRESS 508 Haynes Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jennie Pauline Oliver		4. DATE OF DEATH Month Day Year October 25, 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14 1880
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Carter Samuel Carter Unknown		14. MOTHER'S MAIDEN NAME Mary B. Hyman Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Joyce Connors		Address Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dayton O Watkins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON O WATKINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 28, 1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE He Witt		ADDRESS 10-26 60	
24a. REC'D BY REGISTRAR DATE NOV 4 '60		24b. REGISTRAR'S SIGNATURE	





CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Maryland	
c. LENGTH OF STAY IN 1b 3 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 4730- Homer Ave., S.E.		d. STREET ADDRESS 4730- Homer Ave., S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last ELLA E. OLSON		4. DATE OF DEATH Month Day Year Oct. 17th. 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16- 1890
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Wis.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME <del>XXXXXXXXXXXX</del> ? Frederickson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Benjamin R. Olson -Same as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Combined hypertensive - Atherosclerosis DUE TO Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — (c) —		INTERVAL BETWEEN ONSET AND DEATH 3-4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/25/57, 19 to 10/17/60, 19, that I last saw the deceased alive on 10/16/60, 19, and that death occurred at 11:51 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. C. Lambert		M.D. 2932 Wm. St. S.E. DC 20.	
PHYSICIAN'S NAME (Type) WM. C. LAMBERT M.D.		2932 Wm. St. S.E. DC 20.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 20- 60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers		1661- 4800 Hope Rd. S.E. Washington, D.C.	
24a. REC'D BY REGISTRAR DATE OCT 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH 12-1-28		PLACE OF BIRTH MOBILE, ALA.	
MARRIAGE None		DATE OF MARRIAGE None		PLACE OF MARRIAGE None	
OCCUPATION None		DATE OF OCCUPATION None		PLACE OF OCCUPATION None	
EDUCATION None		DATE OF EDUCATION None		PLACE OF EDUCATION None	
RELIGION None		DATE OF RELIGION None		PLACE OF RELIGION None	
MILITARY SERVICE None		DATE OF MILITARY SERVICE None		PLACE OF MILITARY SERVICE None	
PREVIOUS ILLNESS None		DATE OF PREVIOUS ILLNESS None		PLACE OF PREVIOUS ILLNESS None	
CAUSE OF DEATH None		DATE OF CAUSE OF DEATH None		PLACE OF CAUSE OF DEATH None	
MANNER OF DEATH None		DATE OF MANNER OF DEATH None		PLACE OF MANNER OF DEATH None	
SIGNATURE OF PHYSICIAN None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF WITNESS None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF DECEASED None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF NEXT OF KIN None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF CLERK None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF REGISTRAR None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF JUDGE None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF SHERIFF None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF CORONER None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF JURY None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF COURT None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF JUDGE None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF SHERIFF None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF CORONER None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF JURY None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	
SIGNATURE OF COURT None		DATE OF SIGNATURE None		PLACE OF SIGNATURE None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11733

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>1311 Corbin Place, N. E.</b>			
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>-</b> Last <b>Ouzts</b>				4. DATE OF DEATH Month <b>10</b> Day <b>18</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/15/1885</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>		IF UNDER 24 HRS. Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Henry Shabley</b>				14. MOTHER'S MAIDEN NAME <b>Elvira Martin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>William Ouzts (husband)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-</b> DUE TO <b>-</b> (c) <b>-</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic and hypertensive vascular disease</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>8/1</b> <b>1960</b> to <b>10/18</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>10/18</b> <b>1960</b> , and that death occurred at <b>1:50</b> <b>A. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Moe Weiss</b>				M. D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/18/1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>				22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-22-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stewart</b>				ADDRESS <b>3048 St. N.E.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 19 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

G. L. B.

11731

CERTIFICATE OF DEATH

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

11721

11734

<b>1. PLACE OF DEATH</b> o. COUNTY <b>Prince George</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> <b>Prince George</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>3 Hr 15 Min</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmont Heights 30</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>6100 H St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>Baby Boy</b> <b>Parker</b>				<b>4. DATE OF DEATH</b> Month <b>Oct.</b> Day <b>4</b> Year <b>19 60</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 4, 1960</b>		
				9. AGE (In years last birthday) yrs. <b>9</b>		IF UNDER 1 YEAR Months Days <b>9</b>		
				IF UNDER 24 HRS. <b>15 Min</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Sterling Mathews Parker</b>				14. MOTHER'S MAIDEN NAME <b>Evelyn Delores Thompson</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mother</b>		Address <b>Same</b>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>prematurity, (10 g)</b> DUE TO <b>762.5</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>atelectasis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 4</b> 19 <b>60</b> , to <b>Oct. 4</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Oct. 4</b> 19 <b>60</b> , and that death occurred at <b>10:15 A.M.</b> on the causes and on the date stated above.								
22a. SIGNATURE <b>Thomas A. Christensen</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10/4/60</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas A. Christensen M.D.</b>				22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>10-29-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Maryland</b>		23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>				ADDRESS <b>Administrator</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 1 '60</b>		
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

VR A15 (4)  
15M 9/59

11722

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11735

Item 9 Film 0273 10-24-60 at Items 8, 9 Film G277, 12-27-60 et

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>8 hrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>46 Brentwood</b> d. STREET ADDRESS <b>1 4529 34th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Eva Mary Peltier</b>		4. DATE OF DEATH Month Day Year <b>Oct. 13 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1892</b> <b>12-17-1892</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Felix Styza</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hamerla</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>no</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal carcinoma</b> DUE TO <b>175-0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ovarian carcinoma</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-29</b> 19 <b>60</b> to <b>10-13</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>10-12</b> 19 <b>60</b> , and that death occurred at <b>12:45 AM</b> the causes and on the date stated above.			
22a. SIGNATURE <b>Jeanne C Bateman</b>		22b. DATE SIGNED <b>10/13/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Jeanne C Bateman, M.D.</b>		22d. ADDRESS <b>940- 25th St. N.W. Washington., D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct 17, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>Oct 18 60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Rouse</b>	

1172

1172

STATE OF NEW YORK

IN SENATE,  
January 15, 1915.  
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1914.  
ALBANY:  
J. B. LIPPINCOTT & COMPANY, PRINTERS,  
1915.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11723

11736  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Pr Geo</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chewery</i> c. LENGTH OF STAY IN 1b <i>DOA</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Pr Geo General</i>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Pr Geo</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxon Hill Md</i> d. STREET ADDRESS <i>5525 St Barnabas Rd</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>HARRY SILVESTER PHELPS</i> First Middle Last 4. DATE OF DEATH <i>Oct 29 1960</i> Month Day Year		5. SEX <i>M</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>Dec. 6-1874</i> 9. AGE (In years last birthday) <i>85</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired market worker market</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i> 11. BIRTHPLACE (State or foreign country) <i>USA</i> 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>CLARENCE PHELPS</i> 14. MOTHER'S MAIDEN NAME <i>Virginia Day</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> 16. SOCIAL SECURITY NO. <i>no</i> 17. INFORMANT <i>Virginia Talbert 4949 St Barnabas Rd Oxon Hill Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Surgical Shock</i> DUE TO (b) <i>Internal Hemorrhage - Cerebral Acet</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <i>Fractured Skull, Fractured Ribs</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Skin Foot Cancer at ear</i>	
20a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Struck by an Automobile</i> 20c. STATE OF INJURY Month, Day, Year <i>8:00 o. m. 10-29 1960</i> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Street</i> 20f. (City or town) (County) (State) <i>Oxon Hill P.G. Md.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Dayton Owalter</i> EXAMINER'S NAME (Type) <i>DAYTON Owalter</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>10-29-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>Nov. 1 1960</i> 22c. NAME OF CEMETERY OR CREMATORY <i>Washington Nat'l</i> 22d. LOCATION (City, town, or county) (State) <i>Suitland Maryland</i>		24a. REC'D BY REGISTRAR <i>NOV 1 '60</i> 24b. REGISTRAR'S SIGNATURE <i>William S. Evans</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Bros.</i> ADDRESS <i>1661--Good Hope Rd., SE Washington 20 DC</i>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11749

11737  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Morningside</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Morningside</u>		19	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>21 Pickett Lane</u>				d. STREET ADDRESS <u>21 Pickett Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Weldbourne</u> Last <u>Phillips</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 10, 1910</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General Bldg.</u>		11. BIRTHPLACE (State or foreign country) <u>West of Columbia</u>	
13. FATHER'S NAME <u>Henry Phillips</u>				14. MOTHER'S MAIDEN NAME <u>Zita Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Yessavale Phillips sum up #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO (b) <u>shot gun wound of heart</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>shot self with shot gun</u>					
20c. TIME OF INJURY Month, Day, Year <u>4:00 p.m. 10-23 1960</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Morningside P.G. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>10-24-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/27/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Mason Funeral Home</u>				ADDRESS <u>2500 Nichols Ave</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 2 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert G. Mason</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

(O.E. THOMAS)



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. OCCUPATION		8. MARITAL STATUS		9. EDUCATION		10. RELIGION		11. SOCIAL CLASS		12. DATE OF DEATH	
13. TIME OF DEATH		14. PLACE OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF EXAMINER		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN		21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF NURSE		23. SIGNATURE OF CHURCH		24. SIGNATURE OF OTHER	
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D. O. A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen First Middle Last Adele Potts		4. DATE OF DEATH October 12, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1869
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Freidland Schumann	
14. MOTHER'S MAIDEN NAME Regina Fuchs		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Helen C. Arnold Same as #2 (Daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertrophic arthritis. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dayton O. Watkins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON O. WATKINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-12-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/15/60	22c. NAME OF CEMETERY OR CREMATORY Sharon	22d. LOCATION (City, town, or county) Middleberg, (State) Va.
23. FUNERAL DIRECTOR'S SIGNATURE Frances Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE OCT 17 '60		24b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11684

## CERTIFICATE OF DEATH

11739

Item 7 Film 275 10-20-60 et

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b> c. LENGTH OF STAY IN lb <b>2 YRS.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WASHINGTON, D.C.</b> b. COUNTY <b>WASHINGTON, D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASH. D.C.</b> d. STREET ADDRESS <b>2400 16TH. ST. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ANN</b> Last <b>POWELL</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARITAL STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 15, 1886</b>
9. AGE (In years lost birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>NEWARK, NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>YES</b>	
13. FATHER'S NAME <b>JOHN FRANCIS CONROY</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET MASON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Sr. M. Anne Catherine Brown - 4922 La Salle Road</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> 425-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Atherosclerotic Heart Disease</b> DUE TO (c) <b>over 10 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebrovascular Thrombosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 7, 1958</b> , to <b>October 14, 1960</b> , that (I) (we) last saw the deceased alive on <b>10-8-1960</b> , and that death occurred at <b>12:15 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Michael J. McInerney</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Michael J. McInerney, M.D.</b>		22d. ADDRESS <b>1150 Connecticut Avenue N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>10-17-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. MARY'S CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D. C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		25a. REC'D BY REGISTRAR <b>Oct 17 1960</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CHILLIE L. WILK

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**CERTIFICATE OF DEATH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 4232 Southern Ave., S.E.	
3. NAME OF DECEASED (Type or print) First Middle Last Bernard E. Pumphrey		4. DATE OF DEATH Month 10 Day 14 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/24/1904
9. AGE (In years lost birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab driver		10b. KIND OF BUSINESS OR INDUSTRY Diamond Cab Co.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. Pumphrey		14. MOTHER'S MAIDEN NAME Josephine Rest	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 578-09-1227	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pharynx 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, 7 yrs., 7 months 002X INTERVAL BETWEEN ONSET AND DEATH 5 months 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/3/58 to 10/14/60, that (I) (we) last saw the deceased alive on 10/14/1960, and that death occurred at A. M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE 10/14/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Oct 17-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery, Southland Md		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Semmes Bros		25a. REC'D BY REGISTRAR DATE OCT 18 '60	
ADDRESS 1661-9th Hope Rd S E		25b. REGISTRAR'S SIGNATURE	

1661-9th Hope Rd S E  
 Wash 20800



11730

OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1910

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11724

CERTIFICATE OF DEATH

11741

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Pr. Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pr. Georges Gen. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPHINE</b> Middle <b>A.</b> Last <b>PUMPHREY</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>1st</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 9th 1881</b>	
9. AGE (In years lost birthday) <b>79 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Gov't. Service Incorp.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>? Rest</b>				14. MOTHER'S MAIDEN NAME <b>Eleanor Dresler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-24-8779</b>		INFORMANT <b>James L. Pumphrey</b> Address <b>871--Bellevue Cir. S.E. Washington 20 DC</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic C.V.R. Disease.</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>10-15 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Ant. 15</b> , 19 <b>50</b> , to <b>Ant. 15</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Ant. 15</b> , 19 <b>60</b> , and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6124--Central Ave, Capitol Hghts 10-1-60 Md.</b>							
ACTUAL SIGNATURE <b>William Brainin</b>				PHYSICIAN'S NAME (Type) <b>Dr. William Brainin</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 4th 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros. 1661-Grand Hope Rd.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 4 '60</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

CERTIFICATE OF DEATH

11757

Dr. George

6 4 1900

at the residence of

Dr. George

Dr. George

Dr. George

Dr. George

Dr. George

Dr. George

Dr. George

Dr. George

Dr. George

Dr. George

Dr. George

Dr. George

Dr. George

Dr. George

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11744

11742

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Pr Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Farmington Heights</i>		c. LENGTH OF STAY IN 1b <i>6 years</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Farmington Heights</i>	
f. STREET ADDRESS <i>602-59 ave NE</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>NAPOLEON BONAPART ROBERTSON</i>		4. DATE OF DEATH Month Day Year <i>Oct 29 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-6-09</i>
9. AGE (In years last birthday) <i>51</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>upholsterer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Furniture</i>	
11. BIRTHPLACE (State or foreign country) <i>So. Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Robertson</i>		14. MOTHER'S MAIDEN NAME <i>Hattie Edwards</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>as above</i>	
17. INFORMANT <i>Mrs. Mary Robertson</i>		Address <i>as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Strangulation</i> DUE TO <i>974X</i> Conditions, if any, which gave rise to immediate cause (b) <i>Hanging</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>four minutes</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Subject Hanged Self</i>	
20c. TIME OF INJURY Month, Day, Year <i>8:00 p.m. 10-29-1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Farmington Heights Pr Geo</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Dayton O Watkins</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>DAYTON O WATKINS</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>11-4-60</i>		22b. DATE THEREOF <i>11-4-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat.</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Washington &amp; Sons</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 2 '60</i>	
ADDRESS <i>4925 Ream Ave NE</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>	



VS. A15ME(5)  
5M 9/55

1. PLACE OF BIRTH a. COUNTY <u>Prince Geo</u> <u>MARYLAND</u>	2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr Geo</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chewers</u>	c. LENGTH OF STAY IN 1b <u>DOA</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pr Geo General</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>JOHN JOSEPH ROONEY</u>	4. DATE OF DEATH <u>10-1-1960</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12 1895</u>
9. AGE (In years last birthday) <u>65</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk-retired</u>
11. BIRTHPLACE (State or foreign country) <u>PA.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>JOHN J ROONEY</u>	14. MOTHER'S MAIDEN NAME <u>ANN MURPHY</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes WWI-army</u>	16. SOCIAL SECURITY NO.
17. INFORMANT <u>MARGARET ANDREWS</u>	Address <u>2 M. East Ave Greenbelt Md</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO <u>Myocardial Infarction 1 day</u> DUE TO <u>Thrombosis Rt Coronary Artery 1 day</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Sclerosis</u>	INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <u>NO</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>
22b. DATE THEREOF <u>10/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys - W</u>
22d. LOCATION (City, town, or county) (State) <u>Wilkes Barre Pa.</u>	23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>
23a. ADDRESS <u>5801-Cleveland Ave</u>	23b. REC'D BY REGISTRAR <u>ARTS/60</u>
23c. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	23d. DATE <u>10-2-60</u>

## MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 7 Film 6273 10-24-60 et

11744

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Gordon St.Clair		4. DATE OF DEATH Month Day Year Oct. 15 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 June 1896
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Unemployed	
11. BIRTHPLACE (State or foreign country) Roanoke, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mary E. StClair, 4100 Brooks Dr. Suitland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Bronchiectasis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 30 1960, to Oct. 15 1960, that (I) (we) last saw the deceased alive on Oct. 15 1960, and that death occurred at 3:35 A.M. from the causes and on the date stated above.			
22a. SIGNATURE George William Ware		22b. DATE SIGNED 10/17/60	
22c. PHYSICIAN'S NAME (Type) George William Ware		22d. ADDRESS 900-178 St. h. W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/1960	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co		ADDRESS Riverdale, Md	
25a. REC'D BY REGISTRAR DATE OCT 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

11714

CENTRAL CHAIR OF DEATH

11714

M

FILED IN

MA 67114

1  
FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11727 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11745											
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>P. G.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chenery</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsdale</u>					
c. LENGTH OF STAY in 1b <u>Woodson Avenue</u>						d. STREET ADDRESS <u>1107-59th Ave</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Robert Gordon Schenck</u>						4. DATE OF DEATH <u>Oct 15 1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		DATE OF BIRTH <u>June 6. 1950</u>		9. AGE (In years last birthday) <u>10</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Grade School District of Columbia</u>					
11. BIRTHPLACE (State or foreign country) <u>D. C.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>William Gould Schenck</u>						14. MOTHER'S MAIDEN NAME <u>Leda O. Reese</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>none</u>					
17. INFORMANT <u>William G. Schenck</u>						Address <u>119-35th St SE Washington DC</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and Shock</u> 919.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Shot gun wound of lower abdomen</u> (c) <u>cause test.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>shot gun accidentally discharged</u>					
20c. TIME OF INJURY Month, Day, Year <u>2:10-15 1960</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>In a wooded area Greater Capital Hts P. G. Md</u>						20f. City or town (County) (State) <u>Hillsdale P. G. Md</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James I. Boyd</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>James I. Boyd</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Oct 18-60</u>						22b. DATE THEREOF <u>Oct 18-60</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>						22d. LOCATION (City, town, or country) (State) <u>Bladensburg Md.</u>					
23. FUNERAL DIRECTOR <u>Simmons Bros 1661-4th Ave NE SE Wash DC</u>						24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>					
DATE <u>OCT 19 '60</u>						24b. REGISTRAR'S SIGNATURE					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11728

11746

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph K.</b> Middle <b>Schilling</b> Last <b>Schilling</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>12</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-6-76</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>4</b> Hours <b>1</b> Min. <b>0</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Esso Oil Co.</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-12-3954</b>			
17. INFORMANT <b>Eleanor H. Schilling</b>				Address <b>9208 Annapolis Rd., Lanham, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILATERAL PNEUMONIA</b> DUE TO <b>490X</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 10, 1960</b> to <b>OCT. 12, 1960</b> , that (I) (we) last saw the deceased alive on <b>OCT. 12, 1960</b> , and that death occurred at <b>10:30 A.M.</b> on the date stated above.							
22a. SIGNATURE <b>Bruno Kolega</b>				22b. DATE SIGNED <b>OCT. 12/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Bruno Kolega, M.D.</b>				22d. ADDRESS <b>4833 St. Barnabas Road, S.E.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 14, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO., Riverdale, Md.</b>				25a. REC'D BY REGISTRAR <b>DATE OCT 14 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>							



1178

CERTIFICATE OF DEATH

1178



Unknown  
Germany  
Base 011 Co.  
Unknown  
No  
Eleanor H. Schilling  
9208 Annapolis  
Rd., Lanham, Md.

W. M. CHURCH CO., Silverdale, Md.  
Buried: Oct. 1, 1966 Fort Lincoln Cemetery, Hagerstown, Maryland.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11747

11729

1. PLACE OF DEATH a. COUNTY <u>County Prince George's</u> <small>MARYLAND</small>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>5711 Landover Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Rhonda</u> Middle <u>Gwynne</u> Last <u>Shegogue</u>				4. DATE OF DEATH Month <u>October</u> Day <u>23</u> , 19 <u>60</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 12, 1952</u>		9. AGE (In years last birthday) <u>8</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>school</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John E Shegogue</u>				14. MOTHER'S MAIDEN NAME <u>Roma Gwynne Chambers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Name <u>John E Shegogue</u> Address <u>Cheverly, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>(massive)</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <u>Cerebral locomotor &amp; cutaneous</u>						INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by a car</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>5:20</u> <u>10-7</u> <u>1960</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Cheverly</u> (County) <u>Prince Georges</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dayton Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON OWATKINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 26, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 26 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. Prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
11783		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				11748				
Item 17, Film G-275 11/22/60.cac										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine				c. LENGTH OF STAY IN 1b 10 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Brandywine				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RR #1 Box 16					d. STREET ADDRESS RR #1 Box 16			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Archie First Middle Finton Last Smith					4. DATE OF DEATH Oct. Month 28, Day 1960 Year					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 28, 1899		9. AGE (In years last birthday) 61 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Laborer		10b. KIND OF BUSINESS OR INDUSTRY State of Md.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 1 YEAR Months Days Hours Min.		
13. FATHER'S NAME Wallace B. Smith					14. MOTHER'S MAIDEN NAME Christiana Pinkney					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-12-3757		17. INFORMANT Sadie J. Smith (Wife) Same as No. 2 Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Hypertensive Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) INTERVAL BETWEEN ONSET AND DEATH years										
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Dayton Watkins					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 10-28-60
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-1-60		22c. NAME OF CEMETERY OR CREMATORY Union Bethel		22d. LOCATION (City, town, or county) (State) Brandywine, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland					ADDRESS The Hunt Funeral Home, Waldorf, Maryland		24a. REC'D BY REGISTRAR DATE NOV 2 '60		24b. REGISTRAR'S SIGNATURE Arthur L. House	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY IN 1b 2 yrs., 3 months, and 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital					d. STREET ADDRESS 1710 Gale St., N.E. #2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Lucas Last Smith			4. DATE OF DEATH Month 10 Day 31 Year 19 60						
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/28/1886		9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement worker		10b. KIND OF BUSINESS OR INDUSTRY C. H. Small		11. BIRTHPLACE (State or foreign country) Washington, D. C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Smith					14. MOTHER'S MAIDEN NAME Estelle ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X Far advanced, active, pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Multiple cerebral vascular accidents; generalized arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 7 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7/9/1959 to 10/31/1960, that (I) (we) lost saw the deceased alive on 10/31/1960, and that death occurred at A. M. from the causes and on the date stated above.									
22a. SIGNATURE Moe Weiss					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/31/60		
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.					22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/60		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			23d. LOCATION (City, town, or county) (State) Washington, D. C.		
24. FUNERAL DIRECTOR'S SIGNATURE Alexandra S. Pope, Jr.					ADDRESS 414-15th St, SE		25a. REC'D BY REGISTRAR DATE NOV 4 '60		25b. REGISTRAR'S SIGNATURE



11487

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR OF DEATHS

11487

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11750

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D. O. A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SAMUEL WESTLEY SMITH Sr.</b>		4. DATE OF DEATH Month <b>October</b> Day <b>28</b> , Year <b>19 60</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 1, 1908</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W. S. S. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel W. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Lillie M. Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-05-6564</b>	
17. INFORMANT <b>Helen L. Smith (Wife)</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infartion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Occeluded Right Coronyary Artery</b> DUE TO <b>Caronyary Arteriosclartic Heart Disease</b> (c) <b>Inst.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Inst.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Inst.</b> <b>Years</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Dayton O. Watkins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dayton O. Watkins</b>		DATE SIGNED <b>10/29/60</b>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/31/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>ACT 31 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

# MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH OR 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11750

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Cause of Death		Manner of Death		Occupation	
Time of Death		Place of Death		Signature of Medical Examiner	

<p>1. Name of Deceased</p> <p>2. Sex</p> <p>3. Age</p> <p>4. Date of Birth</p> <p>5. Place of Birth</p> <p>6. Usual Residence</p> <p>7. Cause of Death</p> <p>8. Manner of Death</p> <p>9. Occupation</p> <p>10. Time of Death</p> <p>11. Place of Death</p> <p>12. Signature of Medical Examiner</p>		<p>13. Name of Physician</p> <p>14. Address of Physician</p> <p>15. Date of Examination</p> <p>16. Signature of Physician</p>	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11785

CERTIFICATE OF DEATH

Reg. Dist. No.

11751

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Maryland		c. LENGTH OF STAY IN 1b 6 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL E. SNYDER		4. DATE OF DEATH Month Day Year Oct. 22nd. 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19th 1872
9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Building Contractor.		10b. KIND OF BUSINESS OR INDUSTRY Building Contractor.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry J. Snyder		14. MOTHER'S MAIDEN NAME Anna J. Pope	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Nursing Home Records	
17. ADDRESS Same as # 1.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decubitus Ulcer (c) Generalized Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 mo 1 yr Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-21, 1960, to 10-22, 1960, that I last saw the deceased alive on 10-21, 1960, and that death occurred at 2:55 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 10-22-60	
ACTUAL SIGNATURE John J. Gaedy M.D. 2904 Nichols Ave S.E.		PHYSICIAN'S NAME (Type) John J. Gaedy 2904-Nichols Ave S.E.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 24- 60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers		24a. REC'D BY REGISTRAR DATE OCT 24 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

11781

MINISTRE DE LA SANTE

11782

ADU

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11731

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>P. Geo.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesney</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>P. Geo. General</u>				d. STREET ADDRESS <u>Box 149A RFD #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine Spriggs</u>				4. DATE OF DEATH Month Day Year <u>October 10, 19 69</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-14</u>		9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.B.A.</u>	
13. FATHER'S NAME <u>Joseph Brown</u>				14. MOTHER'S MAIDEN NAME <u>Sadie CRAWFORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. Helen Jones</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Surgical Shock</u> <u>467.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> (c) <u>Enter abdominal abscess?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fibroid uterus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-11-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-14-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Family Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. Smith</u> ADDRESS <u>Wash DC</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Ciriling &amp; House</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



11731

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11731

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. RESIDENCE	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERGY		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL		21. SIGNATURE OF CREMATION	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
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100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

RECEIVED  
BALTIMORE  
MAY 10 1911

## CERTIFICATE OF DEATH

11753

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7508 Gerard Street</b>		d. STREET ADDRESS <b>7508 Gerard Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MINNIE - ELIZABETH-STEVENS</b>		4. DATE OF DEATH <b>OCTOBER 8 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 25, 1866</b>
9. AGE (In years last birthday) <b>94</b> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		<b>Baltimore</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Emory High</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Banks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>Emory H. Kohlhaus, 2203 Alletta St. Zone 27</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>451X</b> IMMEDIATE CAUSE (a) <b>THROMBOSIS, BIFURCATION ABDOMINAL</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ADVANCED ARTERIOSCLEROSIS</b> DUE TO (c) <b>AORTA</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JULY 14, 1948</b> , to <b>OCT 8, 1960</b> , that I last saw the deceased alive on <b>OCT 7, 1960</b> , and that death occurred at <b>3:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Louis Mendel</b>		ADDRESS (Street, city or town, state) <b>4506 COLLEGE AVE</b> DATE SIGNED <b>10/8/60</b>	
PHYSICIAN'S NAME (Type) <b>C. LOUIS MENDEL</b>		<b>COLLEGE PARK Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-12-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		ADDRESS <b>1217 St. Paul Street</b>	
24a. REC'D BY REGISTRAR <b>OCT 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of medical examiner		11. Signature of coroner		12. Signature of jury	
13. Signature of health officer		14. Signature of police officer		15. Signature of fire officer		16. Signature of other official	
17. Signature of witness		18. Signature of witness		19. Signature of witness		20. Signature of witness	
21. Signature of witness		22. Signature of witness		23. Signature of witness		24. Signature of witness	
25. Signature of witness		26. Signature of witness		27. Signature of witness		28. Signature of witness	
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89. Signature of witness		90. Signature of witness		91. Signature of witness		92. Signature of witness	
93. Signature of witness		94. Signature of witness		95. Signature of witness		96. Signature of witness	
97. Signature of witness		98. Signature of witness		99. Signature of witness		100. Signature of witness	

DO NOT WRITE IN THESE SPACES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11732

11754

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>25 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>70 Lakland</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>49002 Navahoe St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>Stroud</u> Last <u>Stroud</u>				<b>4. DATE OF DEATH</b> Month <u>Oct.</u> Day <u>15</u> Year <u>1960</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Black</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>?</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>— — — — —</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Orange Co., N.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Ned Stroud</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Jane Oldham</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>— — — — —</u>		<b>17. INFORMANT</b> Address <u>Care S. Stroud - Burlington, N.C.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>332+</u> IMMEDIATE CAUSE (a) <u>cerebrovascular thrombosis with</u> DUE TO <u>lt. sigmoid hemorrhage?</u> (b) <u>cerebral aneurysm rupture</u> DUE TO <u>generalized arteriosclerosis</u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>  <u>year</u>  <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>60</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept 20</u> 19 <u>60</u> , <b>to</b> <u>Oct 15</u> 19 <u>60</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Oct 15</u> 19 <u>60</u> , <b>and that death occurred at</b> <u>12:10 AM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Till Bergman</u>				<b>22b. DATE SIGNED</b> <u>Oct 15 1960</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. Till Bergman, M.D.</u>				<b>22d. ADDRESS</b> <u>4316 Gallatin St. Hyattsville, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>10-20-60</u>		<b>23b. DATE THEREOF</b> <u>10-20-60</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Queens Chapel</u>		<b>23d. LOCATION (City, town, or county)</b> (State) <u>Murkbuk Md</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H.S. Washington</u>				<b>ADDRESS</b> <u>45-4925 Deane Ave NE</u>		<b>25a. RECEIVED BY REGISTRAR</b> <u>Oct 27 1960</u>	
				<b>25b. REGISTRAR'S SIGNATURE</b> <u>James A. Howard</u>			

1173

CERTIFICATE OF DEATH

1173



Given under my hand and the seal of the Registrar General of Births, Deaths and Marriages, for the District of ...  
this ... day of ... 19...

Witness my hand and the seal of the Registrar General of Births, Deaths and Marriages, for the District of ...

1

Attest my hand and the seal of the Registrar General of Births, Deaths and Marriages, for the District of ...  
this ... day of ... 19...

Witness my hand and the seal of the Registrar General of Births, Deaths and Marriages, for the District of ...  
this ... day of ... 19...

Witness my hand and the seal of the Registrar General of Births, Deaths and Marriages, for the District of ...  
this ... day of ... 19...

Witness my hand and the seal of the Registrar General of Births, Deaths and Marriages, for the District of ...  
this ... day of ... 19...

11786

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>				c. LENGTH OF STAY IN 1b <u>4 DAYS</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CLINTON</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SOUTHERN MARYLAND MEDICAL CENTER</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>1 RT 1 BOX 615</u>			
3. NAME OF DECEASED (Type or print) First <u>MYRTLE</u> Middle <u>IVA</u> Last <u>STUMP</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 10-1879</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. UNDER 1 YEAR Months <u>36</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>		11. UNDER 24 HRS. Months <u>0</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>WILLIAM NEWTON CUTLIP</u>				14. MOTHER'S MAIDEN NAME <u>MIHALO SINGLETON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT Address <u>MRS. NESBITT HENRATTY - RT 1 BOX 615 CLINTON, MD</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL BRONCHOPNEUMONIA</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL HEMMORHAGE</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> 5 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>SEPT</u> , 1959, to <u>PRESENT</u> , that I last saw the deceased alive on <u>OCT. 27</u> , 1960, and that death occurred at <u>6:10</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur Shaver Jr.</u> M.D.				DATE SIGNED <u>BRANCH AVE. - CLINTON, MD. 10/28/60</u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>				ADDRESS (Street, city or town, state) <u>BRANCH AVE. - CLINTON, MD. 10/28/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>REMOVAL</u>		<u>10/29/60</u>		<u>St. Lincolns Cem</u>		<u>Calmar Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm Lee's Sons Co</u>				24a. REC'D BY REGISTRAR <u>3004th st &amp; E.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
DATE <u>OCT 31 '60</u>							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



11786

CENTRAL AIR DR. CREDIT

11786

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11756

Reg. Dist. No.

11733

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> <u>MD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HAILEY</u> First <u>SULLIVAN</u> Middle Last				4. DATE OF DEATH <u>Oct 3</u> 19 <u>60</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-1919</u>	9. AGE (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Hailey Sullivan</u>				14. MOTHER'S MAIDEN NAME <u>Winnie Marshall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-01-3691</u>		17. INFORMANT <u>Records Prince Georges</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Laceration &amp; Contusion</u> 816X DUE TO <u>Fracture skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Locomotor force</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 day</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I on Part II of item 18.) <u>Automobile accident - my</u>			
20c. TIME OF INJURY Month, Day, Year <u>Nov 5, 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) <u>Pr Geo</u> (State) <u>Md</u>		20f. (City or town) <u>Remove extended</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dayton O Waticins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O WATICINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Bros</u> ADDRESS <u>1661-9d Kope Rd SE Wash DC</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kiana</u>	

11754

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11754

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>MALE</u>	
3. AGE <u>45</u>		4. DATE OF BIRTH <u>1910</u>	
5. PLACE OF BIRTH <u>NEW YORK</u>		6. OCCUPATION <u>LABORER</u>	
7. MARITAL STATUS <u>MARRIED</u>		8. EDUCATION <u>HIGH SCHOOL</u>	
9. RELIGION <u>CATHOLIC</u>		10. RACE <u>WHITE</u>	
11. SOCIAL SECURITY NUMBER <u>123-45-6789</u>		12. DATE OF DEATH <u>1955</u>	
13. PLACE OF DEATH <u>HOME</u>		14. TIME OF DEATH <u>10:00 AM</u>	
15. CAUSE OF DEATH <u>HEART DISEASE</u>		16. MANNER OF DEATH <u>NATURAL</u>	
17. SIGNATURE OF EXAMINER <u>[Signature]</u>		18. SIGNATURE OF WITNESS <u>[Signature]</u>	
19. SIGNATURE OF DECEASED <u>[Signature]</u>		20. SIGNATURE OF NEXT OF KIN <u>[Signature]</u>	
21. SIGNATURE OF CLERK <u>[Signature]</u>		22. SIGNATURE OF JURY <u>[Signature]</u>	
23. SIGNATURE OF JURY <u>[Signature]</u>		24. SIGNATURE OF JURY <u>[Signature]</u>	
25. SIGNATURE OF JURY <u>[Signature]</u>		26. SIGNATURE OF JURY <u>[Signature]</u>	
27. SIGNATURE OF JURY <u>[Signature]</u>		28. SIGNATURE OF JURY <u>[Signature]</u>	
29. SIGNATURE OF JURY <u>[Signature]</u>		30. SIGNATURE OF JURY <u>[Signature]</u>	
31. SIGNATURE OF JURY <u>[Signature]</u>		32. SIGNATURE OF JURY <u>[Signature]</u>	
33. SIGNATURE OF JURY <u>[Signature]</u>		34. SIGNATURE OF JURY <u>[Signature]</u>	
35. SIGNATURE OF JURY <u>[Signature]</u>		36. SIGNATURE OF JURY <u>[Signature]</u>	
37. SIGNATURE OF JURY <u>[Signature]</u>		38. SIGNATURE OF JURY <u>[Signature]</u>	
39. SIGNATURE OF JURY <u>[Signature]</u>		40. SIGNATURE OF JURY <u>[Signature]</u>	
41. SIGNATURE OF JURY <u>[Signature]</u>		42. SIGNATURE OF JURY <u>[Signature]</u>	
43. SIGNATURE OF JURY <u>[Signature]</u>		44. SIGNATURE OF JURY <u>[Signature]</u>	
45. SIGNATURE OF JURY <u>[Signature]</u>		46. SIGNATURE OF JURY <u>[Signature]</u>	
47. SIGNATURE OF JURY <u>[Signature]</u>		48. SIGNATURE OF JURY <u>[Signature]</u>	
49. SIGNATURE OF JURY <u>[Signature]</u>		50. SIGNATURE OF JURY <u>[Signature]</u>	
51. SIGNATURE OF JURY <u>[Signature]</u>		52. SIGNATURE OF JURY <u>[Signature]</u>	
53. SIGNATURE OF JURY <u>[Signature]</u>		54. SIGNATURE OF JURY <u>[Signature]</u>	
55. SIGNATURE OF JURY <u>[Signature]</u>		56. SIGNATURE OF JURY <u>[Signature]</u>	
57. SIGNATURE OF JURY <u>[Signature]</u>		58. SIGNATURE OF JURY <u>[Signature]</u>	
59. SIGNATURE OF JURY <u>[Signature]</u>		60. SIGNATURE OF JURY <u>[Signature]</u>	
61. SIGNATURE OF JURY <u>[Signature]</u>		62. SIGNATURE OF JURY <u>[Signature]</u>	
63. SIGNATURE OF JURY <u>[Signature]</u>		64. SIGNATURE OF JURY <u>[Signature]</u>	
65. SIGNATURE OF JURY <u>[Signature]</u>		66. SIGNATURE OF JURY <u>[Signature]</u>	
67. SIGNATURE OF JURY <u>[Signature]</u>		68. SIGNATURE OF JURY <u>[Signature]</u>	
69. SIGNATURE OF JURY <u>[Signature]</u>		70. SIGNATURE OF JURY <u>[Signature]</u>	
71. SIGNATURE OF JURY <u>[Signature]</u>		72. SIGNATURE OF JURY <u>[Signature]</u>	
73. SIGNATURE OF JURY <u>[Signature]</u>		74. SIGNATURE OF JURY <u>[Signature]</u>	
75. SIGNATURE OF JURY <u>[Signature]</u>		76. SIGNATURE OF JURY <u>[Signature]</u>	
77. SIGNATURE OF JURY <u>[Signature]</u>		78. SIGNATURE OF JURY <u>[Signature]</u>	
79. SIGNATURE OF JURY <u>[Signature]</u>		80. SIGNATURE OF JURY <u>[Signature]</u>	
81. SIGNATURE OF JURY <u>[Signature]</u>		82. SIGNATURE OF JURY <u>[Signature]</u>	
83. SIGNATURE OF JURY <u>[Signature]</u>		84. SIGNATURE OF JURY <u>[Signature]</u>	
85. SIGNATURE OF JURY <u>[Signature]</u>		86. SIGNATURE OF JURY <u>[Signature]</u>	
87. SIGNATURE OF JURY <u>[Signature]</u>		88. SIGNATURE OF JURY <u>[Signature]</u>	
89. SIGNATURE OF JURY <u>[Signature]</u>		90. SIGNATURE OF JURY <u>[Signature]</u>	
91. SIGNATURE OF JURY <u>[Signature]</u>		92. SIGNATURE OF JURY <u>[Signature]</u>	
93. SIGNATURE OF JURY <u>[Signature]</u>		94. SIGNATURE OF JURY <u>[Signature]</u>	
95. SIGNATURE OF JURY <u>[Signature]</u>		96. SIGNATURE OF JURY <u>[Signature]</u>	
97. SIGNATURE OF JURY <u>[Signature]</u>		98. SIGNATURE OF JURY <u>[Signature]</u>	
99. SIGNATURE OF JURY <u>[Signature]</u>		100. SIGNATURE OF JURY <u>[Signature]</u>	

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11787

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11757

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 4556 Dix St., N. E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Kathleen - Tate				4. DATE OF DEATH Month Day Year 10 4 1960			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/3/1893		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) British West Indies		12. CITIZEN OF WHAT COUNTRY? Unknown <input checked="" type="checkbox"/>	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent (?)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident (probably thrombosis) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Hypertensive and arteriosclerotic cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH 2 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/29 1960 to 10/4/ 1960, that (I) (we) lost saw the deceased alive on 10/4/ 1960, and that death occurred at 3:24 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/4/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10/5/60		23c. NAME OF CEMETERY OR CREMATORY Unknown		23d. LOCATION (City, town, or county) (State) Body to Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE John I. Limes / Philip Kay 3015 1st. N.E.				ADDRESS 3015 1st. N.E.		25a. REC'D BY REGISTRAR DATE OCT 7 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

Reg: 7 #318

11753

11787

CERTIFICATE OF DEATH

Medical Officer

(Name of Deceased)

(Signature)

(Place of Residence)

(Date of Death)

(Age)

(Occupation)

(Cause of Death)

(Signature of Medical Officer)

(Signature of Registrar)

(Signature of Coroner)

(Signature of Medical Officer)

(Date of Burial)

(Place of Burial)

(Signature of Registrar)

(Signature of Coroner)

(Signature of Registrar)

(Signature of Medical Officer)

(Date of Death)

(Signature of Registrar)

(Signature of Medical Officer)

(Signature of Registrar)

(Signature of Medical Officer)

## CERTIFICATE OF DEATH

11758  
Reg. Dist. No.

11788

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> <u>18</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>				c. LENGTH OF STAY IN 1b <u>3 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>GUDE FARMS outside LAUREL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JANE</u> Last <u>TAYMAN</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>4</u> Year <u>19 60</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 15, 1883</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>FRANK BRYANT</u>				14. MOTHER'S MAIDEN NAME <u>CORA OGILE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO - -</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>EFFIE SMITH - SAME ADDRESS - DAUGHTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>SINCE JULY 4, 1959</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>58</u> , to <u>present</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>OCT 1</u> , 19 <u>60</u> , and that death occurred at <u>10:50</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>402 MAIN ST. LAUREL MD</u> DATE SIGNED <u>10/4/60</u>							
ACTUAL SIGNATURE <u>John R. Buell</u>				M.D. <u>John R. Buell, M. D.</u>			
PHYSICIAN'S NAME (Type) <u>John R. Buell, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Croom Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home - Upper Marlboro, Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

<p>Item 21 Filed 294 11 9 60</p> <p>11789</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> <p>12958</p> <p>Reg. Dist. No.</p>										
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 21, D.C.</b> c. LENGTH OF STAY IN 1b <b>1 year</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Cedarville, Md.</b>					2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 21, D.C. (Forest Hts. Md.)</b> d. STREET ADDRESS <b>203 Miles Drive, SE</b> 6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>HORACE</b> Middle <b>JOHN</b> Last <b>TERRILL</b>			4. DATE OF DEATH Month <b>October</b> Day <b>26</b> Year <b>19 60</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>16 November '33</b>		9. AGE (In years last birthday) <b>26 yrs.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Naval Aviator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Derby, Conn.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Horace T. Terrill</b>				14. MOTHER'S MAIDEN NAME <b>Ethel A. Strand</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>048267922</b>		17. INFORMANT <b>GORDON D. LUCAS, Capt USAF MC</b>			Address <b>USAF Hospital Andrews AFB, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable cause: Central Nervous System Injuries</b> <b>860X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Unsuccessful ejection from Naval Aircraft</b>							
20c. TIME OF INJURY Month, Day, Year <b>4:11 p.m. Oct 26 19 60</b>			20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Open Field</b>		20f. (City or town) (County) (State) <b>Cedarville Prince George Md</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>James I. Boyd</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>10/31/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATL</b>			22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b>					ADDRESS <b>1400 Chapin St. NW Wash, D.C.</b>		24a. REC'D BY REGISTRAR <b>NOV 3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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11734  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11759

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>5 Weeks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitlo Heights</b> d. STREET ADDRESS <b>199 61st. Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Cheryl</b> First <b>Dianne</b> Middle <b>Thibodeau(Ellis)</b> Last		4. DATE OF DEATH Month <b>Oct.</b> Day <b>30</b> Year <b>19 60</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9- Sept. 23, 1900</b>	9. AGE (In years and birthday) yrs. <b>7</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b>	IF UNDER 24 HRS. Hours <b>7</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Henry E. Ellis</b>			14. MOTHER'S MAIDEN NAME <b>Lois Moore</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mother</b> Address <b>Same</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>754.5</b> IMMEDIATE CAUSE (a) <b>Congenital Heart defect</b> DUE TO (b) <b>Immaturity, Prematurity</b> DUE TO (c) <b>Immaturity, Prematurity</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): INTERVAL BETWEEN ONSET AND DEATH <b>Since birth</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Birth</b> 19 <b>00</b> to <b>10/30</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>10/29</b> 19 <b>60</b> , and that death occurred at <b>145 P.M.</b> from the causes and on the date stated above.						
22a. SIGNATURE <b>Dr. Lewis Parker</b> 170		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-31-60</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lewis Parker, M.D.</b>		22d. ADDRESS <b>5211 St. Barbabas Road, Temple Hills, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>11/1/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Maryland</b>		23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>		ADDRESS <b>Administrator</b>		25a. REC'D BY REGISTRAR <b>NOV 4 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Hanna</b>

11434

MINISTRY OF HEALTH  
HOSPITAL OF DUBLIN

11434



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11760

Reg. Dist. No.

11735

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md</b>			c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>44 Cottage City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>3711 41st Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>E.</b> Last <b>Thompson</b>				4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 17, 1913</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shop Foreman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Refuge Collecting Co.</b>			11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Braxton Thompson</b>				14. MOTHER'S MAIDEN NAME <b>Amy May</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>234015192</b>		17. INFORMANT <b>Mary Rose Thompson Cottage City Md. (Wife)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>491X</b> DUE TO <b>aspiration Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>aspiration Pneumonia</b> DUE TO (c) <b>aspiration Pneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid arthritis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>moments</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dayton O. Watkins</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>DAYTON O. WATKINS</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 6, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE OCT 6 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar for to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11685

11761

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4919 49th Ave.</u>		d. STREET ADDRESS <u>4919 49th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>WILTSHIRE</u> Middle <u>B</u> Last <u>USILTON</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 10, 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Family &amp; Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Family &amp; Decorator</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Usilton</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. BIDDLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Norman D. Usilton</u>	
17. INFORMANT <u>Mr. Norman D. Usilton</u> Address <u>17 Rockledge av</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO <u>Cardio Vascular Renal Disease</u> (c) <u>Cardio Vascular Renal Disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>11 Months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 5, 1959</u> to <u>Sept 27, 1960</u> that I last saw the deceased alive on <u>Sept 27, 1960</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Netter</u> M.D.		ADDRESS (Street, city or town, state) <u>1722 Monroe St NE</u>	
DATE SIGNED <u>Oct 7 '60</u>		DATE SIGNED <u>Oct 7 '60</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT R. HOTTEL, M.D.</u>		ADDRESS <u>1722 Monroe St NE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-6-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Riverdale, Md</u>		24a. REC'D BY REGISTRAR <u>Oct 7 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

Coroner Hatfield & approved R.H.

11381

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

11381

Page 1 of 1

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>1965-10-15</i>		6. TIME OF DEATH <i>10:30 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>	
15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>	
39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>	
47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>	
59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>	
63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>	
75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>	
83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>	
87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>	
95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11762	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										11790	
Item 8 Film G274 11-3-60 et										Reg. Dist. No.	
1. PLACE OF DEATH COUNTY <b>Pr. George</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Pr. Geo.</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <b>5530 Ritchie Rd.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First <b>WALKER</b> Middle <b>WALKER</b> Last					4. DATE OF DEATH Month <b>Oct.</b> Day <b>29</b> Year <b>1960</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 14 1889</b> 1881		9. AGE (In years at birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caretaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Cemetery</b>		11. BIRTHPLACE (State or foreign country) <b>D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Unk.</b>					14. MOTHER'S MAIDEN NAME <b>Unk.</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW1</b>		17. INFORMANT <b>Mr. Baltas A. Birkle</b>		Address <b>6750 Marlboro Pike</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Sclerosis</b> (c) <b>arterio Sclerosis Heart disease</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Dexter O. Watkins</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>10/29/60</b>			
EXAMINER'S NAME (Type) <b>Dexter O. Watkins</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 1st 60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Epis. Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Forestville, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros</b>						ADDRESS <b>1661--Good Hope Rd., SE Washington 20 DC</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Travis</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11791

## CERTIFICATE OF DEATH

11763

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges!</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges!</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 3, Box 251</b>				d. STREET ADDRESS <b>Route 3, Box 251</b>			
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Maude</b> Last <b>Watson</b>				4. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>19 60.</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 1, 1887</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.		IF UNDER 24 HRS. Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>James Goldsmith</b>				14. MOTHER'S MAIDEN NAME <b>Ida Baden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Harry L. Watson-#2.</b> Address <b>Same as Item</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic CV Disease</b> DUE TO (c) <b>15 yrs</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ca of Pancreas, Diabetes Mellitus.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>50</b> , to <b>1 Oct</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1 Oct</b> , 19 <b>60</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R B Sasscer</b>				DATE SIGNED <b>10/1/60</b>			
PHYSICIAN'S NAME (Type) <b>Robert B. Sasscer, M.D.</b>				ADDRESS (Street, city or town, state) <b>Upper Marlboro Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/5/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brookfield Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Naylor Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-Upper Marlboro,</b>				24a. REC'D BY REGISTRAR <b>OCT 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneib</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filled with the funeral director's name and address. Page 5 should be filled with the name and address of the person who will receive the body for burial, cremation, or removal.



CERTIFICATE OF DEATH

41791

1178

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
NAME OF PHYSICIAN [Illegible]		NAME OF FUNERAL HOME [Illegible]		NAME OF MINISTER [Illegible]	
NAME OF NEXT OF KIN [Illegible]		NAME OF SURVIVOR [Illegible]		NAME OF WITNESS [Illegible]	
NAME OF REGISTRAR [Illegible]		NAME OF CLERK [Illegible]		NAME OF ASSISTANT CLERK [Illegible]	



This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his or her last illness. It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11792

11764

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PR. GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>		c. LENGTH OF STAY IN 1b <u>26</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9131 7th St.</u>		e. STREET ADDRESS <u>1 9131 7th St.</u>	
3. NAME OF DECEASED (Type or print) First <u>J.</u> Middle <u>OTIS</u> Last <u>WATSON</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5, 1878</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RODERICK WATSON</u>		14. MOTHER'S MAIDEN NAME <u>ZORA - UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. ROSA WATSON</u>		Address <u>9131-7th St. Lanham Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac failure</u> DUE TO (b) <u>Pulmonary Edema</u> DUE TO (c) <u>Cerebral Thrombosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1954</u> to <u>10/12, 1960</u> , that (I) (we) last saw the deceased alive on <u>10/11, 1960</u> , and that death occurred at <u>6:58</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>10/12/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>F. E. MUSSER</u>		22d. ADDRESS <u>4410 74th Ave, Landover Hills</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/15/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>300-4th St. N.E.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		DATE <u>OCT 13 '60</u>	

11704

11701

CHURCH OF DEATH

NO

BRIDGE

BRIDGE

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11736

11765  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE</b> 38		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PRINCE GEORGES GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>5305 67th AVE.</b> 1			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WEDGAR EDWARD WENDORF jr.</b>				4. DATE OF DEATH Month Day Year <b>10 20 19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-22-29</b>	
9. AGE (In years last birthday) <b>31</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRAFTSMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Ind.</b>		11. BIRTHPLACE (State or foreign country) <b>WISC.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDGAR EDWARD WENDORF SR.</b>				14. MOTHER'S MAIDEN NAME <b>GIMMEL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>388-24-3660</b>		17. INFORMANT Address <b>(WIFE) GRACE JUNE WENDORF 5305 57th ave. RIVER.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>few min.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dayton Watkins</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>DAYTON O WATKINS</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>10-21-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial Removal.</b>		<b>10/24/60</b>		<b>Greenwood Cemetery</b>		<b>Racine Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>F. Gasch's Sons Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR <b>OCT 25 '60</b>		24b. REGISTRAR'S SIGNATURE <i>John E. ...</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No.

11793

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>H. Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50th Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6127 Westland Drive</u>				d. STREET ADDRESS <u>16127 Westland Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>L.</u> Last <u>Wetzler</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>7th</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/26/1889</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	IF UNDER 24 HRS. Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Geological Survey</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Boston, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Eugene Wetzler</u>				14. MOTHER'S MAIDEN NAME <u>Anna B. Myster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (unknown))		16. SOCIAL SECURITY NO. <u>518-48-1784</u>		INFORMANT Address <u>above</u> <u>Sadie D. Wetzler, wife</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pyelonephritis, acute &amp; Uremia</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Cerebral thrombosis</u> DUE TO (c) <u>Arteriosclerosis, general</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>3 months</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>August</u> , 19 <u>58</u> , to <u>Oct 7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct 6</u> , 19 <u>60</u> , and that death occurred at <u>5:00</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John F. Brennan Jr.</u>		ADDRESS (Street, city or town, state) <u>M.D. 1034 Perry St. N.E. Wash. D.C.</u> DATE SIGNED <u>10/7/60</u>					
PHYSICIAN'S NAME (Type) <u>John F. Brennan Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/11/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		22d. LOCATION (City, town, or county) (State) <u>West Roxbury, Mass.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home</u>		ADDRESS <u>Mt. Rainier, Maryland</u>		No. REC'D BY REGISTRAR <u>OCT 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11500

CERTIFICATE OF DEATH

11501

County of \_\_\_\_\_

Township of \_\_\_\_\_

Ward of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

Dec. 10, 1900

At \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11767

Reg. Dist. No.

11737

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pr. Geo. Gen. Hosp.</b>				d. STREET ADDRESS <b>3111 Parkway St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PAUL</b> First <b>BEARDSLEY</b> Middle <b>WHITE</b> Last				4. DATE OF DEATH <b>Oct.</b> Month <b>25</b> Day <b>19</b> Year <b>60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/14/09</b>	
9. AGE (In years and birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant (Book)</b>		11. BIRTHPLACE (State or foreign country) <b>Washington</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herman White</b>				14. MOTHER'S MAIDEN NAME <b>Leona Jayne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>550145978</b>		17. INFORMANT <b>Margaret White (Wife)</b> Address <b>Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Corded Vascular</b> DUE TO <b>disease</b> (c) <b>2 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 years</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dayton Watkins</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>DAYTON WATKINS</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>10/28/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

DATE SIGNED

10-26-60

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		Male		45		1910		Baltimore, Md.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
1000 N. E. St.		Carpenter		Heart Disease		Natural		St. Mary's Cemetery	
DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH		HOURS		MINUTES	
1865		1910		10:00		10:00		10:00	
PLACE OF BIRTH		PLACE OF DEATH		PLACE OF BURIAL		PLACE OF INTERMENT		PLACE OF CREMATION	
Maryland		Baltimore, Md.		St. Mary's Cemetery		St. Mary's Cemetery			
DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION	
1910		1910		1910		1910		1910	
NAME OF EXAMINER		NAME OF EXAMINER		NAME OF EXAMINER		NAME OF EXAMINER		NAME OF EXAMINER	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
SIGNATURE		SIGNATURE		SIGNATURE		SIGNATURE		SIGNATURE	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
1910		1910		1910		1910		1910	
NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
SIGNATURE		SIGNATURE		SIGNATURE		SIGNATURE		SIGNATURE	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
1910		1910		1910		1910		1910	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
11743					11768									
CERTIFICATE OF DEATH														
Reg. Dist. No.														
1. PLACE OF DEATH a. COUNTY <b>Prince Georges Co.</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Prince Georges</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District Heights</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>District Heights Medical Center</b>					d. STREET ADDRESS <b>7910 Marlboro Pike</b>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First <b>Maurice</b> Middle <b>S.</b> Last <b>Wildbore</b>					4. DATE OF DEATH Month <b>October</b> Day <b>10th</b> Year <b>19 60</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17th, 1891</b>		9. AGE (In years lost birthday) <b>69</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Metal Heater (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Navy Yard</b>		11. BIRTHPLACE (State or foreign country) <b>Richmond, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>								
13. FATHER'S NAME <b>Frederick Stewart Wildbore</b>					14. MOTHER'S MAIDEN NAME <b>Sarah Armstrong</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT Address <b>Annie M. Wildbore, 7910 Marlboro Pike, Forestville Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>Acute Congestive Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Hypertensive arteriosclerotic H. D.</b> (b) <b>3 Days.</b> (c) <b>6-8 yrs.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
					20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <b>June 14</b> , 19 <b>60</b> , to <b>Oct. 10</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Oct. 10</b> , 19 <b>60</b> , and that death occurred at <b>3:35 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>District Heights Medical Center</b> DATE SIGNED <b>Sidney W. Lowry</b>														
ACTUAL SIGNATURE <b>Sidney W. Lowry</b>					M.D. <b>District Heights Medical Center</b>									
PHYSICIAN'S NAME (Type) <b>Sidney W. Lowry, M. D.</b>					7200 Marlboro Pike, Dist. Heights, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>10/14/1960</b>					22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>				
										22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co., 517--11th St. S.E. Wash. DC</b>					ADDRESS <b>517 13 60</b>					24a. REG'D BY REGISTRAR DATE				
										24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>				





11738

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11769  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hos pital</b>				d. STREET ADDRESS <b>Rt. 2</b>			
3. NAME OF DECEASED (Type or print) First <b>Johney</b> Middle <b>D</b> Last <b>Williams</b>				4. DATE OF DEATH Month <b>October</b> Day <b>13</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 Jan 1927</b>		9. AGE (In years last birthday) <b>33</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farm hand</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Tip Williams</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Johney D. Williams (above)</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Pulmonary embolism while under anesthesia</b> <b>830X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anesthesia given for surgical repair of fractured left femur</b> DUE TO (c) <b>Multiple fractures secondary to Automobile accident</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Truck backed over subject</b> <b>Automobile accident</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>10:10 10-6-60</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Swansons Farm</b>		20f. (City or town) (County) (State) <b>Marlboro Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dayton O Watkins</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>DAYTON O WATKINS</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>10/17/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lanphand Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Surgeonsville Tenn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dr. W. H. Canalean, Laurel, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 1 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneib</b>	

MEDICAL CERTIFICATION

077

1

12

16

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



11734

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11734

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH 1873	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Retired	
7. MARITAL STATUS Married		8. EDUCATION High School	
9. PRESENT RESIDENCE 1234 Elm St., Baltimore, Md.		10. DATE OF DEATH 1945	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF EXAMINER [Signature]		14. SIGNATURE OF WITNESSES [Signatures]	
15. CERTIFICATE OF DEATH This is to certify that the above named person died on the above date at the above place of residence, and that the cause of death was as stated above.		16. SIGNATURE OF REGISTRAR [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
11739				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				11770			
Item 4 Film G273 10-26-60 et Reg. Dist. No.											
1. PLACE OF DEATH o. COUNTY <u>Pr Geo</u> <u>Md</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. LENGTH OF STAY IN 1b <u>DOF</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tuxedo, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo General Hosp.</u>				d. STREET ADDRESS <u>5905 Beacher St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ennis</u> Middle <u>B</u> Last <u>Woodward</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>8</u> Year <u>1960</u>				10, 19 <u>60</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1889</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U S Government</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Samuel Woodward</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Bolen</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>217 09 3407</u>		17. INFORMANT Address <u>Bessie R Woodward Tuxedo Maryland.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 1 day DUE TO <u>430-0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic HEART</u> DUE TO <u>DISEASE</u> (c) <u>1 day</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Oct 13, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			
25. ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-10-60</u>	

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B.P.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11771

1. PLACE OF DEATH o. COUNTY <u>Prince Georges County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>4 days 1 hr. 15 Min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>5030 Nye Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ellie</u> Middle <u>Wright</u> Last <u>Wright</u>		4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-60</u>
9. AGE (In years lost birthday) yrs. <u>3 1/2</u>		10. IF UNDER 1 YEAR Months <u>3 1/2</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cheverly, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Willie Nae Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart attack</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diagnosis Adrenaline</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-16</u> <u>1960</u> to <u>10-20</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>10-19</u> <u>1960</u> , and that death occurred at <u>4:45 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Milos A. Jansa</u>		22b. DATE SIGNED <u>10-21-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Milos A. Jansa, M.D.</u>		22d. ADDRESS <u>7403 Varnum St. Landover Hills, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>11/2/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Prince George's General Hospital, Cheverly, Maryland</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey W. Penn, Jr.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 4 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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CENT HOUSE OF HEALTH

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